

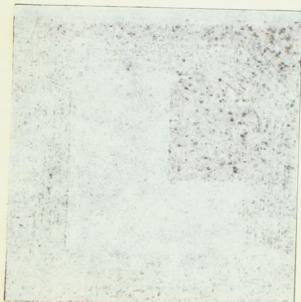
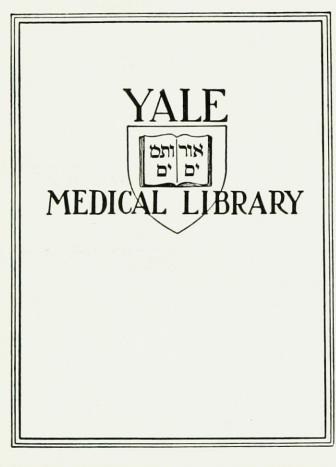
**HEALERS AND PATIENTS**

**The Decision to Seek Unorthodox Health Care**

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**Robert Keene McLellan**

**1978**



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HEALERS AND PATIENTS

The Decision to Seek Unorthodox Health Care

by

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B.A. Yale University 1973

A Thesis Presented to

The Faculty of the School of Medicine

and

the Department of Epidemiology and Public Health

Yale University

In Partial Fulfillment of the Requirements for the Degrees of

Doctor of Medicine and Master of Public Health

1978

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Almost 2500 years ago, the Hippocratic corpus collected doctor's complaints about the nonprofessional criteria that people used to select their physicians, criticism of patients for insisting on "out of the way and doubtful remedies," or on unconventional remedies like "barley water, wine and hydromel," and for disobeying the doctor's orders.

Elliot Freidson

*This, rather than any striking new advances on the part of unorthodox practitioners, is the main reason for the current revival of fringe medicine. People do not visit a fringe practitioner because they are gullible, stupid or superstitious, though they may be: they go to him because they think, or hope, they can get something from him that their doctor no longer gives. They are right; often their doctor does not pretend to be able to give it. It is customary for doctors to lament the spread of fringe systems of treatment, but it is the medical profession itself, through its own failure to provide what the community needs, that must take the responsibility - and the consequences.*

Brian Inglis



## ABSTRACT

Healers and their middle and upper class patients were studied in an exploratory investigation of the decision to seek unorthodox care. Field research consisted of three parts. First, the spectrum of healers in a metropolitan area were identified. Second, five healers representative of this spectrum were chosen for detailed interview and observation. Third, a total of twenty-five patients, five from each of the subject healers' practices, were interviewed. The results question the assumption that the utilization of healers is restricted to the desparate, the medically indigent or unsophisticated, or to the non-medically oriented. Virtually all patients used both orthodox and unorthodox care during their present illness. Factors associated with the choice of an unorthodox source of health care were found in six areas of the patient data: past illness experiences and behavior, medical skepticism, social context, illness and healing beliefs, aspects of the healer-patient interaction, and aspects of the present illness experience. On the basis of suggestive findings, recommendations for further research are made.

## PREFACE

I had planned to study the integration of traditional healers into emerging modern health care systems in West African countries. In preparation for this trip, I had spent a month in the library reading what other people had written about West African healers. Then on the verge of departure, while browsing in a health food store, I overheard an obviously well-to-do shopper ask an employee for an herbal remedy for arthritis. Another person asked about dietary and herbal treatments for diabetes. Later, I spoke with the woman dispensing advice. She told me that herbalists regularly buy botanicals from her to supply their patients. Previously unsuspecting, I realized that I would not have to travel to West Africa to study healers. Not only were "folk healers" practicing in my own town, but it appeared that their use was not restricted to the lower classes or ethnic minorities. Further, more was known about the "exotic" healers of West Africa, than about the unorthodox healers and patients of my own town.

For two years, I have pursued an understanding of the decision of a middle or upper class person to choose a source of unorthodox health care. In the process, I have been helped by many. Of greatest assistance have been the healers and their patients. They offered endless hours of their time in explaining their beliefs and actions. Dave Duncombe was always there when needed. His emotional support, enthusiasm, and constructive criticism made possible what

could never otherwise have been done. Ray Duff and Stanislav Kasl both were helpful in their theoretical critiques. My friends, especially Joan, I could never have done without. Yet, somehow they seemed to understand when I asked them to do without me for still one more day of my work. Mary began, and thank God, Lord Geoffrey in the clutch, finished the typing.

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ALL NAMES USED IN THIS THESIS ARE FICTITIOUS  
ANY RESEMBLANCE TO REAL PERSONS IS COINCIDENTAL

SECTION I

FORMULATION OF THE RESEARCH

CHAPTER I

INTRODUCTION

Doctors are not the only people consulted for health care.

In the United States, there is a vast array of health services available outside of the orthodox profession. Within the last three decades, a great deal has been learned about the process by which a person becomes a doctor's patient, yet little is known about how, when, or why a person decides to seek help from an unorthodox healer.<sup>1</sup> What work has been done, has been largely confined to ethnographic or sensationalist investigations of healing among the lower classes and minority groups of the United States. Using case studies of healers and patients, this thesis will explore the process by which a middle or upper class person, in an urban area, becomes the patient of an unorthodox healer.<sup>2</sup> The results question the assumption that the use of alternative forms of healing is restricted to the ethnic minorities, the poor, the desparate or the socially and medically unsophisticated. The case material suggests a number of other possible explanations of unorthodox illness behavior that merit further investigation.

#### RATIONALE FOR STUDY

One of the earliest stimuli for studying unorthodox illness behavior<sup>3</sup> was the documentation that few symptomatic people actually resort to a physician for care (Zola 1972). Ironically, research focussed on those people who did seek medical care (Mechanic 1959,

1960). Several authors have ascribed this single-minded orientation to a professional bias. (Levin 1976). Legitimate illness behavior was defined as seeking assistance from an orthodox health professional and all other behavior as "delay" (Cowie 1976, Parsons 1951, Zola 1972). Zola (1972) believes that the paucity of research on unorthodox illness behavior is due to a fear that somehow such research would legitimize phenomena that had already been pre-judged as "bad."

The reasons for such a vacuum in this all-important area of medical care is not hard to understand. As elsewhere, in regard to several other areas of socio-medical investigation, it is related to several hidden and inarticulated assumptions about the prevalence (how much of it exists) and the process (why it takes place) which tend to play down the existence of any 'real' issues to study. Here, however, there was additional overlay. For such phenomena - self-treatment as well as the use of 'quacks' or anyone who did not have an MD - was 'bad' in and of itself and therefore not worth investigating except to 'expose' it. Perhaps as seen today in regard to certain drug investigations<sup>4</sup> there was the fear that to even investigate it systematically would give the phenomena some air of legitimacy or, at the very least, publicity and therefore unintentionally encourage the 'evil' practice.

There is a history of looking at the use of non-medical sources of health care in the third world and among the ethnic minorities and lower classes of the Western world (Fabrega 1974 for a review). To Zola (1972), this restriction of scope further connotes that unorthodox practices are perceived by social scientists to be "backward" and "underdeveloped." In any case, most of this work has been ethnographic descriptions of the specifics of curing practices, especially folk psychiatric practices (Fabrega 1974). Otherwise,

research energies have been predominantly directed at understanding alternative healing arts, in an historical and sociological sense as parts of social movements (Hine 1974, Pattison 1974, Pfeiffer 1974).

Unfortunately, data regarding the behavior and symptoms of the sick person who uses alternative forms of health care have seldom been reported (Fabrega 1974, Weidman 1973). In short, there have been few published behavioral studies of the use of unorthodox practitioners (Levin 1976, Mechanic 1966, Wallis 1976, Wardwell 1972, Zola 1972) - particularly by middle and upper income majority groups of the Western world. Little data of even the simplest kind, e.g. utilization rates and characteristics of utilizers, exist. (National Analysts, Inc. 1972, Reed 1932, Roebuck and Hunter 1972). And attempts to apply a systematic, comprehensive theoretical perspective to understanding why and when people use alternative practitioners are exceedingly rare (Freidson 1972, Suchman 1965, Nudleman 1976). How these alternative practitioners are used in conjunction with other competing unorthodox and orthodox health care systems in this country has been scarcely explored (Garrison 1972, Scott 1975).

There is reason to believe that the deficiencies in this research have begun to be alleviated (Wallis 1976, World Health 1978). Zola (1972) attributes the reversal of traditional research policies to the penetration of some long-standing observations:

- (1) that in no predictable future will there be in either the developed, the developing, or underdeveloped countries sufficiently qualified (by current standards) physicians to service adequately the populace; (2) that despite massive educational and legal efforts, people continue to

self-medicate and go outside the orthodox medical services; (3) that perhaps such forms of doctoring do or can do 'some' good; (4) that for an increasing number of conditions the treatment of choice is the patient management and administration of a particular medical regimen.

Nonetheless, again the focus has been on unorthodox illness behavior as it exists in the third world (Fabrega 1973, 1974; Hughes 1963; MacLean 1965a,b, 1966, 1969; Schwartz 1969), or various minority or lower socio-economic groups in the United States (Garrison 1972, Nudelman 1976, Romano 1965, Scott 1975).

#### FIELD WORK

To redress these deficiencies in the understanding of unorthodox illness behavior, a field study was undertaken. I<sup>5</sup> investigated the decision of physically ill, middle and upper class patients to seek unorthodox health care. As will be detailed in Chapter 3, the field work consisted of three parts. The initial task was to, in a small metropolitan area, identify all the types of unorthodox healing arts used by physically ill, middle and upper class people. Based on this information, a taxonomy of healing was devised as the primary tool for elucidating the relationship of one healer to another, and of patients to healers. Second, five healers (hereafter - subject healers), each representative of different points in this taxonomy were selected for detailed study. Third, a total of twenty-five patients (hereafter - sample patients), five from each of the subject healers' practices, were also selected

as study participants. Both healers and patients were intensively observed and interviewed in an attempt to understand the patients' choice of an unorthodox source of health care.

## OVERVIEW

What will follow are ideas - the results of an exploration. No presumption is made that they are generalizable. No representative samples have been drawn.<sup>6</sup> What few numbers are presented are only of significance as they pertain to the group interviewed. Nor has my purpose been to authoritatively describe different ways of healing or to document their efficacy. Principally, using case studies, I mean to provoke, to question assumptions and to suggest new avenues of research on unorthodox illness behavior.

The first section of the thesis is devoted to a statement of the research problem (Chapter 1), a review of what is known about unorthodox illness behavior (Chapter 2), and a description of the methods of study (Chapter 3). Section Two (Chapter 4) presents the results of the first part of the field study - the identification of healers in an urban area. In this chapter, healers are enumerated and a method of categorizing them is explicated. Section Three (Chapters 5-10) is devoted to case studies of each of the five healers selected for intensive investigation. Chapter 10 discusses general themes which have emerged from the study of the healers, in particular, the gift of healing and the relationship of a healer's

healing philosophy to the type of interaction the healer has with a patient. Section Four (Chapter 11) describes the patient sample, the utilization behavior of the patients, and factors identified as associated with the patients' choice of unorthodox care. In Section Five, after discussing the limitations of the information obtained from the field study (Chapter 12), I review the healer and patient data in light of the existing literature on illness behavior (Chapter 13). Based on the study findings, ideas for further research are indicated.

CHAPTER 2

BESIDES THE DOCTOR

This chapter briefly reviews what is known about unorthodox healers and the people that consult them. A number of theoretical considerations which have emerged from the more general study of illness behavior are also presented as tools which aid the study of unorthodox behavior.

#### THE HEALING SCENE

If nothing else, there can be no mistake that, along with the high prevalence of medical symptoms, a vast array of unorthodox healing practices flourish today in the United States (Cornacchia 1976, National Analysts, Inc. 1972, Roughman and Haggerty 1972). Scientific medicine does not begin to encompass the range of beliefs and practices dealing with illness and healing in our culture. Saunders and Hewes (1953) point out that there are at least fifty different kinds of persons, aside from qualified medical professionals, from whom one may seek medical advice or treatment (eg. psychics, spiritualists, faith healers, occult practitioners, chiropractors, root workers, espiritistas, medicine men, herbalists, etc.). They go on to note that besides consulting somebody, one can visit a place (eg. hot springs, shrines, health spas.), purchase an appliance (eg. hot water bottle, elastic stockings), or patent medicine (eg. hair tonic), use a household remedy (eg. garlic), follow a procedure (eg. eye exercises, prayer, diet) or turn to the written word (eg. Prevention Magazine). Nor is there reason

to believe that these practices are any less common today than they were at the turn of the century (New Haven Health Care 1975, Reed 1952, Kett 1968, Shyrock 1967). Ethnomedical studies in the inner city and areas of rural poverty have revealed a range of health practices matching that found in less industrialized societies (Fabrega 1974, Garrison 1972, Frank 1961, Kiev 1964, Torrey 1972 provide reviews).

From what can be gleaned from circumstantial evidence, unorthodox health practices are not restricted by demographic boundaries. The popular press has created the impression that the alternative healing arts are "in"-- along with natural foods. Faith healing, reflexology, yoga, laetrile-- the list goes on-- have attracted the attention of an untold number of well-educated, middle and upper class patients (Block 1977, Briggs 1977, Kernan 1977, Seder 1977, Time Magazine 1977). A multitude of conferences and symposia have been held which directly address the relevance of alternate forms of healing in the health care system.<sup>1</sup> Comprehensive guides to alternative healing resources have been published (Healing Resources Inc., 1977) and bibliographies compiled (Levin 1976, Popenoe 1976). Even the President's sister has become famous as a faith healer. Freidson spoke for many health professionals when in 1961, he said

That the problem (of unorthodox health practices) continues is somewhat paradoxical, for it seems unquestionable that the medical practitioner has reached an all-time peak of prestige and authority in the eyes

of the public.... His knowledge is now far more precise than it has ever been in the past.

The urgency to understand the tenacity of unorthodox practices and their place in the health care system has only become more immediate since Freidson's statement. What has changed is that the authority and prestige of the physician has begun to erode, as the medical profession sustains mounting criticism from all social levels of the public, the popular press and the government (Haug 1969).

Few attempts have been made to bring order to the wide variety of unorthodox practices of healing that exist (Wallis 1976, Wardwell 1972a,b). As noted previously, Saunders and Hewes (1953) classified them crudely in categories of people to consult, places, appliances, patent medicines, procedures and books. The emphasis of my work is on the first category-- the healing arts as practiced by healers. Usually healers are classified only by their techniques eg. chiropractors, herbalists, etc. This approach is not particularly helpful in understanding their relationship to each other or to scientific medicine. Indeed, techniques per se often do not distinguish between healers of different categories in this system of classification. An herbalist uses herbs, but so does a naturopath, a homeopath, and some orthodox doctors (eg. digitalis leaf). This classification also affords us little insight into why patients might seek out the various healers, beyond looking for particular

techniques, nor what kind of relationship the patient might have with the practitioner.

Wardwell (1972b) offered an alternative, medicocentric approach based on structural or legal considerations. He classified all practitioners in terms of their relationship to physicians. This classification may be adequate for probing the dynamics of the relationship of physicians to other practitioners, but it does not yet approach the problem of why people seek out particular healers.

#### THE UNORTHODOX PATIENT

A few scholarly studies do exist which have approached the task of identifying just who does use unorthodox care. As has already been indicated, the balance of this work has been directed a priori at the lowest social classes. Several early investigators supported the assumption that the utilization of non-medical personnel was largely confined to the lowest social classes (Freidson 1972, Jaco 1972, Koos 1954, Roebuck and Hunter 1972, Suchman 1965). Factors such as language and transportation difficulties, social distance and lack of a cultural fit between specific beliefs and practices have been the traditionally accepted reasons for people to use folk health care systems (McGorkle 1961, Scott 1975). Other authors recognizing that these explanations were inadequate, speculated more broadly. Cobb (1958) encapsulated many of these other proposals in his suggestion that there

were four categories of patients who "detour to quacks": miracle seekers, the uninformed, the impatient, and the desparate.

The weight of the circumstantial evidence indicates that none of these customary hypotheses fully encompasses the rationale for the apparently broad spectrum of people that currently seek unorthodox health care. The scanty, but more reliable data is reviewed here.

Most studies estimate that perhaps 75 percent or more illness episodes are cared for without professional intervention. (Levin 1976; White 1961; Zola 1966,1972). The majority of these episodes are probably cared for without resort to anyone but family or friends, i.e. self-care. Self-care practices have been found to be nearly universal among people of all social classes (Levin 1976). An unknown proportion of this self-care can be considered "unorthodox" (see footnote 3, chapter 1).

A number of studies have rebutted the doctrine that medical folk practices and opinions are restricted to the lower social classes (Cassee 1970, Roebuck and Hunter 1972, Strauss 1969) or to the socially dislocated (Garrison 1974, Hine 1974). Hine's (1974) findings regarding Pentacostalism, an unorthodox religious group in which faith healing plays a part, may be true for other unorthodox health practices as well. He says, "The fact that Pentacostalism spreads rapidly among the migrants, the dislocated, and the displaced in any society is irrefutable. Unfortunately, for this type of analysis, it also spreads successfully among life long urbanites." And, Garrison (1974) notes

that the only important characteristic of Pentacostals distinguishing them from major church members of the same socio-economic class and sub-culture, was that Pentacostals make a conscious choice of a minority religious affiliation. Roebuck and Hunter (1972) found that in a sample of 100 people of mixed ethnic and socio-economic status (75% had more than 12 years of education), 67% stated they would be willing to engage an unorthodox healer. Their conclusion was, "Obviously the medical and scientific establishments' definitions of deviance in the area of health care are at variance with the definitions of this sample."

Recent work has also added more perspective on why people consult alternative healers. Beyond the traditionally quoted reasons for unorthodox illness behavior, Coe (1970) cited the fractionation of patient care as a possible rationale. Cornaccia (1976) includes the desire for emotional support unavailable from many doctors as another possibility. In a sociological commentary on the Dianetics movement, Wallis (1976a) suggests that many of the healing movements such as Christian Science and New Thought offer a means of overcoming the gap between expectations and performance in the realm of physical healing. Their emphasis on the whole person de-emphasized the importance of the cure. Finally, he proposes that the bureaucratization and the scale of modern urban society have produced a context in which many individuals experience a lack of control over their destiny and environment--

a sense of being moved and constrained by forces beyond their control. Utilizers of Dianetics sought some means of greater control over their environment.<sup>2</sup>

The data also suggest that unorthodox health care is most frequently used, not to the exclusion of professional medical services, but in tandem with them (Levin 1976, Scott 1975). Kessek and Shepherd (1965), in a study of the characteristics of people who had not attended their physician for from two to ten years, found that attenders, in general, used unorthodox care more frequently than non-attenders. In short, unorthodox health care resources are apparently not used instead of, but as supplements to, going to the doctor.

#### REACTION OF THE AUTHORITIES

Good utilization statistics are hard to come by in the area of alternative health care. Evidence suggests that medical authorities are nevertheless impressed with the implication of what has been described by some as a new social movement (Levin 1976). The Food and Drug Administration (1977) sent out a special notice to all physicians regarding its opinions in the Laetrile controversy-- and included a sign, to be posted in doctor's waiting rooms, warning patients of the dangers of Laetrile. The Food and Drug Administration also sponsored a national survey of folk medical practices which derided their "rampant empiricism" (National Analysts, Inc, 1972). Congressional representatives

from a growing number of states have been pressured by their constituents to legalize the substance, in spite of the medical profession's denuncements of it. Statewide anti-fluoridation initiatives have taken similar form (Evans and Pickles 1975). Further, a Medical Freedom of Choice Act, guaranteeing a person's right to freely choose whatever type of treatment s/he desires, has been proposed by Laetrile proponents.<sup>3</sup> No less than the Director of Health Services for the American Association of Medical Colleges and the Deputy Director of the National Institutes of Mental Health spoke approvingly at a recent wholistic health care conference, in Washington, D.C. (Stress Without Stress, Oct. 13,14, 1977), of the contemporary examination of alternative healing arts. That alternative health practices are already affecting the existing health care system is corroborated by the funding of an Acupressure and Holistic Health Training Program on August 19, 1976 by the State of California Department of Health under the aegis of AB1503.<sup>4</sup> Further, the administrator of the Health Services Administration of the Department of Health, Education and Welfare introduced a conference entitled "Holistic Health: A Public Policy".<sup>5</sup>

#### CONTRIBUTIONS FROM THE STUDY OF ILLNESS BEHAVIOR

The literature devoted to illness behavior is voluminous. Fortunately, good reviews abound (Becker 1974; Kasl 1974; Kasl and Cobb 1966; Kirscht 1974; McKinlay 1972; Mechanic 1966;

Rosenstock 1966, 1974; Zola 1972). The purpose in this section is not to contribute another review of this literature, but simply to present a number of concepts from this work that have guided my study of unorthodox illness behavior.

### Approaches

In a review article, McKinlay (1972) points to six approaches that have been consistently employed in the study of the use (or lack of use, or delay in use) of medical care resources: economic, socio-demographic, geographic, psychosocial, socio-cultural, and organizational. In describing these approaches, he joins Zola (1973) in bemoaning the paucity of research which has been aimed at explaining the process by which a person becomes a patient.

Many studies only isolate and study differences in people who have or haven't made a decision to seek some form of medical care. Attention is seldom given to how specific individuals and groups made a particular decision, what factors or what individuals are influential in making this decision, or why one form of behavior is preferred to another.

McKinlay (1972) concludes his review with a call for flexible methodological approaches to the study of illness behavior, rather than "artificially sophisticated research schemes." He emphasizes the need for small scale exploratory work aimed at generating hypotheses about the decision-making process.

The field study was designed with this need in mind. Economic, socio-demographic and geographic factors have been considered as variables in investigating the sample patients'

use of unorthodox care. The emphasis in the formulation of my research, however, was employing a method that would yield insight into the process by which a person becomes an unorthodox patient. For this emphasis, I looked principally to decision theoretic models of illness behavior. These models reflect the psychosocial and socio-cultural approaches to the study of illness behavior. Organizational factors were also studied to better understand the interaction of a patient with a source of care.

#### The Process of Becoming a Patient

A number of authors have conceptualized illness as progressing in stages (Fabrega 1974, Friedson 1961, Kasl and Cobb 1966, Robinson 1971, Suchman 1965, Zola 1973). Some of the ideas emerging from this work have been particularly helpful in formulating the methods used for my study of unorthodox illness behavior.

Friedson (1960) described the process of seeking help as a "career" which relates to the stages of an illness. He pointed out that before seeking health services, a person consults people in his/her lay referral structure.

Indeed, the whole process of seeking help involves a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant authoritative laymen, until the 'professional' is reached. This network of consultants, which is part of the structure of the local lay community and which imposes form on the seeking of help, might be called the 'lay referral structure'. Taken together with the cultural understandings involved in the process, we may speak of it as the 'lay referral system.'

Schwartz (1969) joined Paul (1955), Friedson (1960) and others

(reviewed by Fabrega 1974), in hypothesizing that potential sources of care are arranged in a hierarchy of resort. He pointed out that a patient's culture contained not only norms about the problems patients perceive, but also the norms about the chronological order of services to seek in getting help for those problems. Consultants occupying different places in the hierarchy are used as an illness progresses and according to their place in the individual's acculturative process.

#### Psychosocial Approach

The psychosocial approach is epitomized by the Health Belief Model (Rosenstock 1966). Kirscht (1974) has adapted this comprehensive model to relate the health beliefs of an individual to his/her illness behavior. A psychological state of readiness, composed of conflicting health beliefs (i.e. perceived threat of a medical problem versus the perceived benefits of and barriers to taking action) is proposed to antedate a given choice of action. In theory, a "cue" prompts a person in a given state of readiness into taking an action believed to decrease the threat (or consequences) of an illness. The translation of beliefs into action is thought to be modified by such personal characteristics of the decision-maker as demographic variables, health motivation, and attitudes toward health care providers. Sick-role behavior is also modified by the patient's expectations and satisfactions with the provider (Becker 1974).<sup>6</sup>

One of the least researched aspects of this explanation

of health decision making is the cue to action (Rosenstock 1974). The cues to action are the most immediate factors to influence a person to seek health services. In illness, cues may be either internal, eg. perceptions of bodily states, or external, eg. interpersonal actions, work performance. Obviously, the type and severity of a symptom is an important cue (Freidson 1960, Suchman 1965, Zola 1964). The consensus of authors, however, is that whether the cue be internal or external, it is socially mediated. Considerable research has documented that, given a particular symptom, there is a wide variety of thresholds, dependent on socio-economic and ethnic status, for complaining and acting on the symptom (Freidson 1961; Kirscht 1974; Koos 1967; Stoeckle et al 1963, Zbrowski 1952; Zola 1964, 1966). Other writers have suggested that the symptoms which are usually the focus of the doctor-patient interactions are often beside the point. They are offered by the patient as the culturally approved means of gaining admission to the doctor's office, but are not the patient's underlying major complaint (Balint 1966, Modell 1961, Yudkin 1961). Either consciously or unconsciously, patients may be primarily seeking relief of psycho-social stress when visiting physicians (Mechanic 1962). This stress may or may not be directly related to the patient's symptom (Yudkin 1961). A patient with a cold may visit the doctor because of the cough that prevents sleep or because the patient wants to talk about his relationship with his wife. In neither case is the symptom itself the

"cue" for consulting the doctor, e.g. during the day the cough may not "bother" the patient.<sup>7</sup>

### Socio-cultural Approach

Socio-cultural factors have been exhaustively documented as affecting patients' illness behavior (cf. p.22). Suchman's (1965) work is particularly important because he attempted to examine behavior within the broad framework of a socio-cultural setting, rather than to identify single specific factors associated with behavior. He proposed a model of illness behavior in which these socio-structural elements are the core variables. Suchman located an individual in a group structure along a spectrum from parochial to cosmopolitan. This location depended on the person's ethnic exclusivity, friendship solidarity and orientation toward family tradition and authority. The other axis used to describe a person's place in a group structure was his or her medical orientation ranging from popular (folk) to scientific. Medical orientation was measured by a person's knowledge about disease, skepticism of medical care, and dependency in illness. Suchman's model analyzed the relationship of the social factors of demographic and social group characteristics to the medical factors of health status and source of medical care as mediated by individual medical orientation. Briefly, his conclusion was that a cosmopolitan social background predisposed one to a scientific medical orientation and to promptly seek medical care. On the other hand, a parochial background was more likely to be associated

with a popular medical orientation and a delay in seeking scientific medical care. Not surprisingly, the cosmopolitan was usually of higher social class than the parochial. This model was of particular interest in designing my field study because I intended to purposely study the exceptions to Suchman's conclusions.

#### Organizational Approach

In the formulation of my research, I have also drawn on the organizational approach to the study of utilization behavior. A voluminous literature has documented the effect of various aspects of the source of care on patient behavior (McKinlay 1972), i.e. characteristics of the health care provider and the setting in which s/he works.

#### SUMMARY

A review of the literature on the use of unorthodox healers has revealed large gaps in information. Reliable statistics are scarce, but circumstantial evidence indicates that a great number of healers are practicing in the United States. A middle and upper class social movement appears to be supportive of unorthodox illness behavior, while medical authorities are active in their efforts to denigrate it. Approaches used in the more general study of illness behavior can be helpful, without constraining the design of a field study to contribute to the understanding of how, when, and why middle and upper class people resort to alternative health care.

## CHAPTER 3

### METHODS

The field study was designed to explore the reasons for unorthodox illness behavior among the middle and upper class. Based on the existing literature, a number of research questions directed, without limiting, the research. The search was not for statistical answers to these questions, but for suggestive impressions.

#### RESEARCH QUESTIONS

1. How widespread is the use of alternative ways of healing among the middle and upper classes? How many healers practice in the study area who cater to these classes? What are the different types of healing practiced? Are the practices illegal?
2. Who are the healers? What are their backgrounds and beliefs? How knowledgeable are they about contemporary orthodox medicine? Can we understand their ways of healing by understanding them as people?
3. What characteristics of the varied healing arts seem to attract patients? Which characteristics repel patients? What are the similarities and differences among the healing practices? To what extent do healers deal with the psycho-social and spiritual aspects of health and healing? Where is the locus of control in the healer-patient relationship? Does the healer attempt to increase the patient's freedom of choice of behavior or does the healer concentrate more narrowly on curing disease?
4. What kind of interaction exists between the diverse healing systems? Do patients use multiple systems? Serially? In tandem? At what stages of an illness are the different healing arts employed?
5. Are the healers and/or patients anti-medical doctor in attitude? How closely do the expectations of the healer and patient match? How congruent are their world views and health beliefs? Does the healing interaction lead to a convergence in the healers' and patients' explanation of an illness?

6. What is the medical role of unorthodox healing? Anecdotally, is it efficacious? Would any of the alternate healing arts be compatible with medicine in an adjunctive role for various treatment regimens?

7. Do the alternative practices raise new perspectives on healing theory or the theory of health and disease?

8. Who uses the unorthodox practitioners among the middle and upper classes? For what reasons? Are the patients and their problems different than those presenting to orthodox practitioners? Are the patients medically and socially sophisticated? Do they seek greater control over their health care? What is their general health status? How sophisticated are they in their knowledge of the alternative healing practice? What is the quality of their communication with their healer? What is their illness experience? What has been their career of seeking care?

There were three parts to the field study. First, in a small metropolitan area, I identified the broad spectrum of unorthodox healers used by middle and upper class people. Second, a small sample of healers representative of the spectrum available in this area was selected for study. Third, from each subject healer's practices, a sample of patients was also chosen.

#### PART 1: THE HEALING SCENE

Without hoping to be complete, I attempted to identify at least the majority of unorthodox healers frequented by middle and upper class people in a small metropolitan area. In this way, I hoped to delineate the range of possible sources for health care and at the same time familiarize myself with the sub-culture (or perhaps simply the social circles) of unorthodox healing. I also hoped to gain a subjective impression of the number of people involved in these practices.

For the purposes of this study, an unorthodox (alternative or folk) healer (or, hereafter, simply "healer") was defined as any person who purported to affect the physical state of his/her patients using methods that were not scientifically substantiated or were not in keeping with contemporary medical practice. This definition did not exclude the possibility that a medical doctor could be considered an unorthodox healer, eg. a homeopath (cf. footnote 1, Chapter 1). Other people beyond the healer's circle of friends must have concurred with his/her alleged claim to being a healer. The healer must also have claimed curative as well as preventive powers.

A priori, two groups of healers were excluded from consideration even though they met these prerequisites. Chiropractors were not interviewed or enumerated for a number of reasons: (1) Considerable research about chiropractic has already been reported which encompasses many of the issues I might otherwise want to investigate. This information is readily available (New Haven Health Care, Inc. 1975; McGorkle 1961; Reed 1932; Wardwell 1972). (2) As a licensed and widespread healing art, chiropractic has become, from a popular viewpoint, almost an accepted, conventional form of health care. They practice quite openly, are reimbursed by the Federal government, as well as numerous other third party payers, and are consulted by a substantial minority (25% of Connecticut residents (New Haven Health Care, Inc. 1975).

The other group excluded from investigation was the orthodox

clergy. The rationale for their exclusion was that they sometimes serve as ancillary practitioners in the physician's team. Like psychologists, clergy people are generally accepted by the medical profession as having a function in the overall medical treatment of many patients (Paulsen, 1976).

The middle and upper classes were defined as Classes I, II, and III using Hollingshead's (1957) criteria.

The small metropolitan area was defined as the Greater Erehwon Area including Mammoth Park, East Erehwon, New Erehwon, North Erehwon, West Erehwon and Woody Hills. Only healers whose primary practice was in this area were at risk of inclusion in this study.

For the most part healers were identified by reputation. Many names were gathered by frequenting health food stores, healing meetings, and other activities where one might expect to learn about healers in the area. Phonebooks and occasionally healers' advertisements were also helpful. Finally, names were solicited by notices in local newspapers and health food stores (Appendix A).

A rough directory was created which included each healer's name, address, phone number and type of practice. Every healer so identified was initially approached by letter, phone call, visit, or introduction through a patient or friend. Every healer was then briefly interviewed to obtain at least the baseline information necessary to classify and select subjects for further study (Appendix B).

As pointed out in Chapter 2, existing methods of categorizing healers are not particularly helpful in understanding why a person chose a given healer. Therefore, one of the principal tasks of the first part of the field study was to devise a system of classifying healers that would assist in explaining their patients' illness behavior. The classification was founded on information collected from initial contacts with the many healers of Greater Erehwon. Accordingly, the taxonomy is best explicated together with the results of Part 1 of the field study in Chapter 4. Suffice it to say at this point that based on the question, "How does healing occur?" seven healing philosophies were distilled from the short interviews of all healers identified in the Greater Erehwon area: Fundamentalist, Charismatic, Perfectionist, Spiritual, Religious Orthodox, Vitalist, and Technical. The philosophies define the categories by which each healer was classified.

#### PART 2: THE SUBJECT HEALERS

One approach to studying illness behavior is to focus on the patient. As has been observed in Chapter 2, however, characteristics of the source of care, eg. the doctor (healer) - patient relationship, are thought to influence the patient's illness (sick-role) behavior. Consequently, the decision was made to study unorthodox healers along with their patients. For practical, as well as theoretical, reasons it was decided to identify patient subjects through their healers.

A priori, it was felt that unorthodox patients might be otherwise difficult to contact. This approach would have the advantage of interviewing several patients from each healer, thereby multiplying the opportunity for studying a particular healer's interaction with his/her patients.

Five healers were selected for intensive investigation as examples of the range of healing philosophies identified in the study area: a Fundamentalist who was a faith healer, a group of Perfectionists who were Sikhs, a Spiritual healer who was a psychic, a Vitalist who was a homeopath, and a Technical healer who was a nutritional and Laetrile therapist. These healers were chosen on the basis of the following, non-probabilistic criteria: (1) each was an example of a different healing philosophy, (2) each had a patient volume that was relatively high in comparison to other healers within that category, (3) I had developed good rapport with them on initial contact, and (4) each represented a different organization of care delivery.

Two categories of healing were not represented: Religious Orthodox and Charismatic. As has been mentioned (p. 28), the Religious Orthodox was excluded a priori. A Charismatic healer was not included for practical reasons. The amount of time involved in the study of a healer and his/her patients limited my work to five healers. Charismatic was the category deleted because the two most important charismatic healers in the study area were unable to participate in the study due to other commitments.

After obtaining informed consent (Appendix C), I used a variety of techniques to construct a profile of the healer and his/her practice. The personal profile was based on 15 to 80 hours spent with each healer in observation and interview. Observation of healing sessions was always preceded by obtaining the informed consent of participating patients. The formal interview consisted of 4-8 hours of semi-structured discussion with each healer. The interview instrument (Appendix D) served as a guide of areas to be probed, rather than as a source of ready-made questions. A great deal of information was also gathered during much less formal conversations. The baseline information collected for every healer's profile consisted of: social attributes (eg. demographic); religious beliefs, affiliations and practices; significant personal or family past medical history; background to involvement in healing; attitudes toward and knowledge of scientific medicine; beliefs about health, disease and healing; relationship with patients.

Through observation, interview, and a survey of patient visits, the practice profile was established. Areas of interest included in the data base were methods of healing, charge for services, spectrum of patients treated, healer's perceived place in the patient's hierarchy of resort, interaction with other alternative or orthodox practitioners and organizations. The survey of patient visits was designed to obtain picture of the types and numbers of patients seen by the healer. Each healer received

printed forms (Appendix E) which they were to complete after each patient contact on randomly chosen days during the month of August (chosen for convenience). The actual number of days for which a given healer was instructed to complete forms was dependent on my subjective impressions of their patient volume. Thus, the healer with the highest patient volume was told to complete forms for a total of 3 days, whereas the healer with the smallest patient load was asked to complete a form for every patient seen during the month.

Section III will present the results of Part 2 of the field work in the form of 5 case studies.

#### PART 3: THE SAMPLE PATIENTS

Only class I, II, or II patients who presented to their healers with physical symptoms were included in the study.

From each healer's practice, a study sample of five patients was purposively selected. Choices of subjects, were made in conjunction with the healer with reference to the spectrum of his/her patients. Patients were chosen specifically to encompass this spectrum. If chosen, a patient was initially invited to participate in the study by the healer with the presentation of an informed consent form (Appendix F). Participation consisted of allowing my observation of treatments and 3-8 hours of semi-structured discussion with me about their illness and beliefs. All information was collected from the patient except when s/he was a young child or was unable to

speak. In these cases the mother or spouse spoke for the patient. As with the healer, an instrument was designed to serve as a guideline to areas of discussion, rather than as the basis of standardized questioning (Appendix G). The minimum data base consisted of: social attributes, personality, chief complaint, history of present illness, career of seeking care, expectations and satisfactions with the healer-patient relationship, past medical history, general health status, health behavior, illness behavior, knowledge of scientific medicine, barriers to and attitudes toward professional medical care.

Excerpts of verbatims of patient interview are presented in Section IV to illustrate characteristics of unorthodox illness behavior.

#### SUMMARY OF METHODS OF DATA COLLECTION

In summary, the first part of the field study consisted of collecting data about healers in Greater Erehwon by reputation and short interview. The second part focussed on 5 healers who were studied by observation, intensive interview, and a survey of patient visits. In the third part, 25 sample patients were interviewed.

#### THE BOUNDS

Aside from the patient visit survey, this study was founded entirely on my impressions and interpretations as gathered through semi-structured, but intensive observation and discussion. All information collected, including medical diagnoses, health status, treatment efficacy, etc., is presented as it was perceived and reported by healers and patients. Data was stored by verbatim field

notes, without the assistance of a tape recorder. Further, with the primary intent of collecting subjective data from the variety of healers and patients engaged in unorthodox healing practices, non-probabilistic sampling techniques were used. As a result, no claim is made for the generalizability of the findings. Rather, they are extensive case histories which can serve as a rich lode for ideas.

Finally, two issues, although relevant and intrinsically of great interest should be specifically noted as being beyond the scope of this work. First, no attempt has been made to exhaustively or authoritatively describe the healing practices themselves. Only enough information is provided to orient the reader to the settings in which healer and patient is acting. For more detailed descriptions, the reader will be referred to bibliographic sources. Second, the efficacy of the various healing arts has not been tested or documented. On the other hand, when relevant to the behavior and beliefs of an individual, anecdotal evidence may be cited.

## SECTION I FOOTNOTES

### CHAPTER 1

<sup>1</sup>Distinguishing orthodox from unorthodox practice is problematic. Inglis (1964) has observed that,

To distinguish between orthodox and fringe medicine is not quite so easy as it may seem. In Britain, what is orthodox is established by convention rather than by regulation; once qualified, a doctor may practice any form of medicine he likes, provided he does not break the laws of the land or the by-laws of his profession - which are less concerned with what he does than how he does it: they are primarily a code of conduct... The distinction between orthodoxy is basically a matter of professional organization.

The conventions of organized medicine are different from country to country, eg. homeopathy is not unorthodox in Britain. Accordingly, part of the contemporary American Medical Association's by-laws, the consultation clause, as first adopted in 1847, is used here to define the unorthodox practitioner. "No one can be considered as a regular practitioner, or fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession." (Wardwell 1972) For the following discussion, an unorthodox (alternative or folk) healer (hereafter simply healer) is defined as any person who practices medicine using methods that are not scientifically substantiated or are not in keeping with contemporary American medical practice. This definition is further refined for use in the field study in the Methods chapter.

<sup>2</sup>An unorthodox patient is considered to be any person who consults a healer for health advice or treatment.

<sup>3</sup>Kasl and Cobb (1966) originally distinguished health, illness, and sick-role behavior. Although these distinctions have some theoretical value in that they identify what might be thought of as modal mental states preceding a given action, they blur in reality. Illness and sick-role behavior are particularly indistinct. Therefore, for the purposes of this study, the term illness behavior will be used, unless otherwise stated to denote both illness and sick-role behavior. Unorthodox illness behavior, then, will be defined as the unorthodox actions a symptomatic person takes in an attempt to identify and alleviate what is wrong. "Unorthodox actions" are any

which are not condoned or implemented by an orthodox health professional. By this definition some self-care actions will be orthodox; eg. using insulin appropriately, washing a recent wound with soap and water, etc., and others will be unorthodox, e.g. wearing a pyramid to cure the flu, self-medication with aspirin for a persistent fever. Again, as in Footnote 1, the distinction between orthodox and unorthodox is not always clear, eg. is a lay person using orthodox medical methods, to diagnose and treat a condition such as vaginal mon lia, unorthodox? Physicians would disagree in condoning or condemning such practices.

<sup>4</sup>The current controversy regards Laetrile, cf. Crile (1976), Inglefinger (1977), Moertel (1978), Newell (1978), Relman (1978).

<sup>5</sup>Because of the intensive personal involvement in the collection of data by interview, the more informal convention of the first person is used in reporting the results of the study.

<sup>6</sup>An exception to this generalization was made in an attempt to obtain an accurate picture of each of the study healer's patient populations. As is detailed in Chapter 3, however, practical considerations affected my ability to do this. Hence, no samples used in this study can be considered truly representative.

## CHAPTER 2

<sup>1</sup>Examples of Symposia that have been sponsored in recent years include: Ancient and Modern Healing from Shamanism to Biofeedback (sponsored by the East West Center for Holistic Health) New York, November 12-13, 1977; The Dimensions of Healing - A Symposium (Academy of Parapsychology and Medicine and Stanford University) Stanford, September 30-October 3, 1972; Health and Healing: Ancient and Modern (Albert Einstein Medical School and the Institute for the Study of Human Knowledge) New York, April 2-3, 1977; Stress Without Distress. East-West Academy of Healing Arts, Washington, D.C. October 13-14, 1977

<sup>2</sup>The similarity, in both concerns, and methods of resolution, with people of industrially undeveloped cultures is striking.

<sup>3</sup>In Connecticut, Representative McKenna has introduced House Bill #5304 entitled "Medical Freedom of Choice."

<sup>4</sup>AB 1503 is recent California legislature act (1972) which "authorizes the State Department of Health to approve experimental health manpower pilot projects sponsored by non-profit educational institutions or non-profit community hospitals or clinics for the purposes of developing new kinds of health care delivery systems."

<sup>5</sup>The flyer for this symposium states that:

Holistic Health: A Public Policy will provide a national forum for health related policy-makers and professionals from both public and private sectors to explore the "State of the Art" of Humanistic Medicine, Holistic Health and alternative healing arts; and to formulate recommendations to be presented to the Secretary of HEW, Joseph A. Califano, Jr., and the House and Senate Subcommittees on Health for their consideration in developing a national health policy.

<sup>6</sup>As explained in Footnote 3, Chapter 1, illness behavior and sickrole behavior have been collapsed for the purposes of the thesis into the single term illness behavior, unless otherwise stated.

<sup>7</sup>Some symptoms, eg. those stemming from major trauma, are more likely to be associated with universal and familiar meaning, i.e. loss of life or limb, than others and, as such, are more likely to invariably prompt consultation of a physician. Further, one can characterize certain qualities of symptoms, eg. unfamiliarity (Freidson 1961), which are usually associated with help seeking behavior. Nonetheless, the point remains that rarely is knowledge of a person's symptoms alone sufficient to explain all the variance in a person's illness behavior.

## SECTION I

### REFERENCES

#### Chapter I

Cowie B: The cardiac patient's perception of his heart attack. Soc Sci Med 10: 87-96, 1976

Crile G: Legalization of laetrile - a suggestion. N Engl J Med 295: 116, 1976

Fabrega H: Disease and Social Behavior, Cambridge, Massachusetts, The MIT Press, 1974

Fabrega H and Silver D: Illness and Shamanistic Curing in Zinacantan: An Ethnomedical Analysis. Stanford, California: Stanford University Press, 1973

Freidson E: Client control and medical practice, Patients, Physicians, and Illness, Second Edition. Edited by EG Jaco, New York, The Free Press, 214-221, 1972

Garrison V: Espiritismo: implication for provision of mental health services to Puerto Rican populations. Paper read at the Eighth Annual Meeting of the Southern Anthropological Society, Columbia, Missouri, Feb. 24-25, 1972

Hine VH: The deprivation and disorganization theories of social movements, Religious Movements in Contemporary America. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 418-455, 1974

Hughes CC: Public health in non-literate societies, Man's Image in Medicine and Anthropology. Edited by I Galston, New York, International Universities Press, 157-233, 1963

Inglefinger FJ: Laetrilomania. N Engl J Med 296: 1167-1168, 1977

Inglis B: Fringe Medicine. London, Farber and Farber, 1964

Kasl SV and Cobb S: Health behavior, illness behavior, and sick role behavior. Arch Envir Hlth 12: 246-266, 531-541, 1966

Levin LS, Katz AH, Holst E: Self-Care - Lay Initiatives in Health. New York, Prodist, 1976

Maclean CMU: Tradition in transition: A health opinion survey in Ibadan, Nigeria. *Brit J Prev Soc Med* 19: 192-197, 1965a

\_\_\_\_\_: Traditional medicine and its practitioners in Ibadan, Nigeria. *J Trop Med and Hyg* 68: 237-244, 1965b

\_\_\_\_\_: Hospitals or healers? An attitude survey in Ibadan. *Human organization* 25: 131-139, 1966

\_\_\_\_\_: Traditional healers and their female clients: An aspect of Nigerian sickness behavior. *J Hlth Soc Behav* 10: 172-186, 1969

Mechanic D: Illness and social disability - some problems in analysis. *Pacific Soc Rev* 2: 37-41, 1959

\_\_\_\_\_: Response factors in illness: the study of illness behavior. *Soc Psychiatry* 1:11-20, 1966

\_\_\_\_\_: and Volkart E: Illness behavior and medical diagnoses. *J Hlth Hum Behav* 1: 86-94 Summer 1960

Moertel CG: A trial of Laetrile now. *NEJM* 298: 218-219, 1978

National Analysts, Inc: A Study of Health Practices and Opinions. Springfield, Virginia, National Technical Information Service, U.S. Department of Commerce, June 1972

Newell GR: Why the National Cancer Institute chooses a case-record review of Laetrile. *NEJM* 298: 216-218, 1978

Nudelman AE: The maintenance of Christian science in scientific society, Marginal Medicine. Edited by RF Wallis and P Morley, London, Peter Owen Limited, 42-60, 1976

Parsons T: The Social System. New York, Free Press, 1951

Pattison EM: Ideological support for the marginal middle class: faith healing and glossolalia, Religious Movements in Contemporary America. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 418-455, 1974

Pfeiffer L: The legitimation of marginal religions in the United States, Religious Movements in Contemporary America. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 9-26, 1974

Reed LS: The Healing Cults, Publications of the Committee on the Costs of Medical Care, Number 16, Washington, D.C., The Committee on the Costs of Medical Care, 1932.

Relman AS: Laetrilomania - again. NEJM 298: 215-216, 1978

Romano IOV: Charismatic medicine, folk-healing, and folk-saint-hood. Amer Anthropologist 67: 1151-1173, 1965

Schwartz LR: The hierarchy of resort in curative practices: The Admiralty Islands, Melanesia. J Hlth Soc Behav 10: 201-209, 1969

Scott CS: Competing health care systems in an inner city area. Human Organization 34: 105-110, Spring 1975

Suchman EA: Social patterns of illness and medical care. J Hlth Hum Behav 6: 2-16, 1965

Wallis RF and Morley P, editors: Marginal Medicine. Peter Owen Limited, London, 1976

Wardwell WI: Orthodoxy and heterodoxy in medical practice. Soc Sci Med 6: 759-763, 1972

Weidman HH and Egeland JA: A behavioral science perspective in the comparative approach to the delivery of health care. Soc Sci Med 7: 845-860, 1973

World Health. Geneva, World Health Organization, January 1978

Zola IK: Studying the decision to see a doctor. Adv Psychosom Med 8: 216-236, 1972

## Chapter 2

Ambulatory Chiropractic Practice in Connecticut. New Haven, New Haven Health Care, Inc., 1975

Balint M: The drug "doctor," Medical Care - Readings in the Sociology of Medical Institutions. Edited by WR Scott and EH Volkart, New York, John Wiley and Sons, Inc., 281-291, 1966

Becker MH: The health behavior model and sick-role behavior, The Health Belief Model and Personal Health Behavior. Hlth Educ Monog 2: 409-419, 1974

Blocks: Treating your feet. New Haven Advocate, August 17, 1977

Briggs KA: "Charismatic Christians" seek to infuse the faith with their joyous spirit. The New York Times, July 22, 1977

Cassee ET: Deviant illness behavior: patients of mesmerists. Soc Sci Med 3: 389-396, 1970

Cobb B: Why do people detour to quacks. Patients, Physicians, and Illness, Second Edition. Edited by EG Jaco, New York, The Free Press, 283-287, 1972

Coe RM: The Sociology of Medicine. New York, McGraw Hill, 1970

Cornacchia HJ: Consumer Health. Saint Louis, The CV Mosby Company, 1976

Evans CA and Pizkles T: Statewide antifluoridation initiatives: a new challenge to health workers. AJPH 68: 59-52, 1978

Fabrega H: Disease and Social Behavior. Cambridge, Massachusetts, The MIT Press, 1974

Frank J: Persuasion and Healing, Revised Edition. New York, Schocken Books, 1974

Freidson E: Patients' Views of Medical Practice. New York, Russell Sage Foundation, 1961

\_\_\_\_\_ : Client control and medical practice, Patients, Physicians, and Illness, Second Edition. Edited by EG Jaco, New York, The Free Press, 214-211, 1972

Garrison, V: Espiritismo: implications for provision of mental health services to Puerto Rican populations. Paper read at the 1972 Annual meeting of the Southerns Anthropological Society

\_\_\_\_\_ : Sectarianism and psychosocial adjustment - a controlled comparison of Puerto Rican Pentecostals and Catholics, Religious Movements in Contemporary America. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 418-455, 1974

Haug MR and Sussman MB: Professional autonomy and the revolt of the client. Social Problems 17: 153-161, 1969

Healing Resources: A Comprehensive Guide to Alternative Therapy, Preventive Medicine, and Wholistic Health Practitioners. Silver Spring, Maryland, Health Resources, Inc., 1977

Hine, VH: The deprivation and disorganization theories of social movements, Religious Movements in Contemporary America. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 646-671, 1974

Kasl SV: The health belief model and behavior related to chronic illness. Hlth Educ Monog 2: 433-454, 1974

\_\_\_\_\_ and Cobb S: Health behavior, illness behavior and sick-role behavior. Arch Environ Hlth 12: 246-265, 531-541, 1966

Kernan M: Sampling therapy: 60 ways to health and peace? The Washington Post, January 24, 1977

Kett JF: The Formation of the American Medical Profession. New Haven, Yale University Press, 1968

Kiev A: Magic, Faith, and Healing. New York, The Free Press, 1964

Kirscht JP: The health belief model and illness behavior. Hlth Educ Monog 2: 387-408, 1974

Koos EL: The Health of Regionville. New York, Hafner Publishing Company, 1954

Levin LS, Katz AH, Holst E: Self-care - Lay Initiatives in Health, New York, Prodist, 1976

McGorkle T: Chiropractic: a deviant theory of disease and treatment in contemporary Western culture. Human Organization 20: 20-23, 1961

McKinlay JB: Some approaches and problems in the study of the use of services - an overview. J Hlth Soc Behav 13: 115-152, 1972

Mechanic D: The concept of illness behavior. J.Chron Dis 15: 189-194, 1962

\_\_\_\_\_ : Response factors in illness: The study of illness behavior. Soc Psychiat 1: 11-20, 1966

Modell W: Belief of Symptoms. St. Louis, The CV Mosby Company, 1961

National Analysts, Inc: A Study of Health Practices and Opinions. Springfield, Virginia, National Technical Information Service, U.S. Department of Commerce, June, 1972

Paulsen AE: Religious healing. JAMA 86: 1519-24, 1617-23, 1692-97, 1926

Popenoe C: Books for Inner Development. Washington, D.C. Random House, 1976

Reed LS: The Healing Cults, Publications of the Committee on the Costs of Medical Care, Number 16. Washington, D.C., The Committee on the Costs of Medical Care, 1932

Roebuck JB and Hunter RB: The awareness of health care quackery as deviant behavior. *J Hlth Soc Behav* 13: 162-166, 1972

Rosenstock IM: Why people use health services. MMFQ, Part 2, 44: 94-127, 1966

: The health belief model and preventive health behavior. *HLTH ED MONOG* 2: 354-386, 1974

Roghmann K and Haggerty R: The diary as a research instrument in the study of health and illness behavior. *Med Care* 10: 143-163, 1972

Saunders L and Hewes GW: Fold medicine and medical practice. J Med Ed 28: 43-46, 1953

Schwartz LR: The hierarchy of resort in curative practices: The Admiralty Islands, Melanesia. *J Hlth Soc Behav* 10: 201-209, 1969

Scott CS: Competing health care systems in an inner city area. Human Organization 1: 105-110, 1975

Seder E: Faith healers (parts 1-4). The New Haven Register, September 29, 30, October 1, 3, 1976

Shyrock RH: Medical Licensing in America. Baltimore, Maryland, The Johns Hopkins Press, 1967

Stoeckle JD, Zola IK and Davidson GE: On going to see the doctor, the contributions of the patient to the decision to seek medical

Strauss AL: Medical organization, medical care, and lower income  
S. S. M. 2, 1962.

Suchman FA: Social patterns of illness and medical care. J Hlth  
Wkly Rpt 16: 1065-1070, 1965.

\_\_\_\_\_ : Stages of illness and medical care, Patients Physicians  
Edited by EG Iossi, New York, The Free Press, 1972.

Time: Back to that old time religion. Time-Life, Inc., December 26, 1977

Torrey EF: The Mind Game. New York, Bantam Books, 1972

Wallis R: Dianetics: a marginal psychotherapy, marginal medicine. Edited by Wallis R and Morley P, London, Peter Owen, Limited, 77-102, 1976a

\_\_\_\_ and Morley P: Marginal Medicine, London, Peter Owen Limited, 1976b

Wardwell WI: Orthodoxy and heterodoxy in medical practice. Soc Sci Med 6: 759-763, 1972a

\_\_\_\_: Limited, marginal and quasi-practitioners, Handbook of Medical Sociology, Second Edition. Edited by HE Freeman, S Levine and L Reeder, Englewood Cliffs, New Jersey, Prentice Hall, Inc., 250-273, 1972b

White KL et al: The ecology of medical care. NEJM 265: 885-892, 1961

Yudkin S: Six children with coughs. The second diagnosis. Lancet 2: 561-563, 1961

Zbrowski M: Cultural components in responses to pain. J Soc Iss 8: 16-30, 1952

Zola IK: Illness behavior of the working class, Blue Collar World. Edited by Shostack and Gomberg, Englewood Cliffs, Prentice Hall, 350-361, 1964

\_\_\_\_: Culture and Symptoms. Amer Soc Rev 31: 615-630, 1966

\_\_\_\_: Studying the decision to see a doctor. Adv Psychosom Med 8: 216-236, 1972

\_\_\_\_: Pathways to the doctor - from person to patient. Soc Sci Med 7: 677-689, 1973

### Chapter 3

Ambulatory chiropractic practice in Connecticut: New Haven, New Haven Health Care Inc., 1975 (mimeo)

Hollingshead AB: Two Factor Index of Social Position, New Haven, Hollingshead, 1957

McGorkle T: Chiropractice: a deviant theory of disease and treatment in contemporary Western culture. Human Organization 20: 20-23 Spring 1961

Paulsen AE: Religious healing. JAMA 86: 1519-24, 1617-23, 1692-97, 1926

Reed LS: The Healing Cults. Publications of the Committee on the Costs of Medical Care, Number 16, Washington, D.C. The Committee on the Costs of Medical Care, 1932

Wardwell WI: Limited, marginal, and quasi-practitioners, Handbook of Medical Sociology. Edited by HE Freeman, S Levine, and L Reeder, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 250-275, 1972

SECTION II  
THE HEALING SCENE

CHAPTER 4

HEALERS IN GREATER EREHWON

In this chapter the field is described - the place and its healers. After a brief description of Greater Erehwon, a picture of the variety of healers in Greater Erehwon is painted. As the framework with which to order this array, a system of classification of healers is explicated. Finally, the meaning of this data is interpreted in the context of a discussion of the relevance of their classification for the study of illness behavior.

#### **GREATER EREHWON**

Greater Erehwon consists of a central city, New Erehwon, surrounded by a number of progressively more rural suburbs.<sup>1</sup> Situated on an arm of Long Island Sound, New Erehwon is 70 miles Northeast of New York City. Three small rivers converge to form the bay and harbour of New Erehwon. Large areas of undeveloped land within the city leave room for many parks. Outside New Erehwon farms and watershed lands abruptly demarcate the city from its Western suburbs.

New Erehwon serves as a major wholesale center for New England. Its busy harbour is an important Northeastern point of distribution for oil and gasoline. Many light industries and colleges contribute to the employment opportunities of the area.

#### Cultural Life

The cultural life of Greater New Erehwon is dominated by the presence of a major Ivy League university and several other private, state and community colleges. Besides the museums, libraries, and

activities associated with these schools, there are theaters, cinemas, a city arena, and a symphony orchestra to enrich the cultural life of the area.

#### Social Structure

The social structure of Greater Erehwon has been subject to changes similar to other Northeastern cities. Between the 1960 and 1970 census, as a whole the Greater Erehwon Area increased from about 320,000 to about 350,000, but the central city declined from about 150,000 to 137,000 - a decrease of approximately 9 per cent. At the same time that the white population declined in New Erehwon by almost 30 per cent, however, the non-white population increased by about 66 per cent. Further, the outlying suburbs absorbed much of the urban white exodus. The total suburban population increased from about 170,000 to almost 220,000 in 1970 - representing almost a 30 per cent increase in size.

In the last two decades the social structure of Greater Erehwon has changed little in spite of the spatial redistribution of its inhabitants. Foreign immigration during this time has been minimal. By 1970, only 8 per cent of the population of Greater Erehwon was foreign born, although persons of foreign stock, first and second generation immigrants made up a large proportion of the population, about 30 per cent. Those of Italian extraction are the largest group of foreign stock, followed by the Irish and Russian, Polish, Austrian,

and German Jews. Blacks comprised about 11 per cent of the population and Hispanics constitute about 2 per cent.

The relative distribution of social classes has also remained stable over the last two decades: Class I - about 3 per cent of the population, Class I - 9 per cent, Class III - 21 per cent, Class IV - 49 per cent, and Class V - 18 per cent. The lower classes tend to be confined to the crowded run-down sections of the central city, whereas the upper classes live in the more spacious residential areas of New Erehwon or its rural suburbs.

#### Orthodox Medical Resources

As the home of a major academic medical center, Greater Erehwon is well-endowed with orthodox medical resources. Besides the University hospital, there is a medium sized private community hospital and a Veteran's Administrative Hospital. Two pre-paid health plans and a Medical Foundation enroll many of the middle and upper class residents of Greater Erehwon. Numerous clinics directed at lower income, elderly, or other limited parts of the population also exist. Typically, physicians and their offices are clustered around the hospitals.

#### THE HEALERS

As had been predicted, a large number and a wide variety of unorthodox healers, serving the middle and upper classes, practice in the Greater Erehwon area. Eighteen months were used in the

initial stages of identifying healers and familiarizing myself with their practices. Three months were devoted exclusively to this endeavor. I could never be confident that I had identified all alternative forms of healing used by the middle and upper classes. In the first place, there is no master list with which I could compare my sample place. Second, the number and variety of unorthodox healers was constantly changing. Instead, closure of this stage of work was determined by the admittedly subjective impression that I had contacted all of the most important players in the field. This impression grew from the fact that more and more frequently I was being told of healers that I had already contacted. Further, I assumed that new names, unknown by most contacts, were not particularly important in the community in terms of treating large numbers of people.

The task of enumerating healers was not so straightforward as finding out how many doctors, lawyers or hairdressers practice in the area. There are no directories of unorthodox healers in Greater Erehwon. Few advertise in the yellow pages, newspapers, or billboards. And, there are not many with shingles outside their doors. On the other hand, with personal contact, healers and patients talked freely about their experience with various forms of healing. The fact that I was a medical student, rather than inhibiting, encouraged my informants' enthusiasm. A pervasive, and often explicitly articulated, desire to attract the attention and

acceptance of "open-minded" orthodox medical professionals seemed at least partially, responsible for the interest in talking to me. In the end I was placed on the mailing lists of several healing organizations and was otherwise kept abreast of important events or newcomers in the healing field by faithful contacts.

During the early months of the field study, many healers were identified. My task became one of understanding the differences between them. Many dimensions were considered. The common denominator of these approaches was that they all were aimed at illuminating the reasons for a patient to choose a healer of a particular category. Dimensions that corresponded to variables thought to affect illness behavior were therefore considered, eg. organization of care, types of treatment, personality of healer. Ultimately, because beliefs are so often cited as motivating factors in a person's decision to seek health care, it was decided that a taxonomy of healing that distinguished practitioners on the basis of their healing philosophies was needed.

As data from the initial phase of the research became available, the Spectrum of Healing Philosophies was designed. Serendipitously, as will unfold in ensuing chapters, several other variables, possibly relevant to illness behavior, were found to be associated with a healer's healing philosophy, i.e. personal characteristics of the healer, locus of control in the healer-patient relationship, and healer's beliefs about disease, treatment and cure. The explanation of the classification system is based on the data collected from

healers practicing in the Erehwon area. The practitioners identified in each category of healing are enumerated along with the explication of the categories. Reference to Charts 4A and 4B throughout the discussion of the Healing Spectrum will assist the reader in understanding the text.

Seven basic healing philosophies have been identified and serve as the basis for the categorization: Fundamentalist (Type I), Charismatic (Type II), Perfectionist (Type III), Spiritual (Type IV), Vitalist (Type V), Religious Orthodox (Type VI), and Technical (Type VII) (cf. Chart 4A). The reader should be warned that the descriptions of the philosophies are not meant to reflect how healing actually occurs. Nor are they intended to be faithful to extant theological or other relevant doctrines. Rather, they reflect my subjects' perceptions of how the healing process occurs. Labels of categories should be thought of only in the context of their definition within the study and not as they may be more broadly applicable to theology and philosophy.

The major elements of a healer's philosophy by which s/he is classified is (1) his/her beliefs in the presence of a higher power in the healing process and (2) his/her beliefs in the relative importance to the healing process of the higher power. The patient, and the healer. (The roles of other potential participants, e.g. the family and the community are not related to this scheme of classification.) Note in Chart 4A that a higher power symbolized

CHART 4A  
THE HEALING SPECTRUM

PHILOSOPHY	ROLE IN HEALING PROCESS		
I FUNDAMENTALIST			
II CHARISMATIC			
III PERFECTIONIST			
IV SPIRITUAL			
V VITALIST			
VI RELIGIOUS ORTHODOX*			 
VII TECHNICAL			

KEY:  = HIGHER POWER

 = HEALER

 = PATIENT

The larger the figure the greater the responsibility in the healing process.

\*Two healers are represented in this category, the medical doctor, large square and the clergyperson, small square. See text.

## CHART 4 B

## HEALERS IN EREHWON

PHILOSOPHY	TREATMENT TECHNIQUES	VARIETY OF HEALERS	NUMER OF HEALERS IDENTIFIED
Fundamentalist	Faith healing: Logos therapy, symbols of prayer, laying-on-of-hands; group and individual healing	Assembly of God, Church of Latter Day Saints, Faith Renewal Center, Seventh Day Adventist, Healing Groups, faith healer	8 churches 8 churches 2 healing groups 1 faith healer
Charismatic	Faith healing: laying-on-of-hands, prayer, symbols, therapeutic community; group and individual healing	Catholic, Episcopal, & non-denominational healing services; order of St. Luke healing groups; Christian commune; chaplains of order of St. Luke	8 churches 1 Christian commune 3 healing groups 5 unaffiliated individuals
Perfectionist	Chanting, diet, herbs, prayer, Logos therapy, meditation, therapeutic community, yoga; faith healing; group and individual healing	Christian Science practitioners, Unity School of Christianity, Sikhs	7 individuals 2 healing groups
Spiritual	Color therapy, "energy transmission" laying-on-of-hands, trance states, meditation, visualization, "absent" and individual healing	Psychic healing groups; psychic healers, mediums, and spiritualists	16 individuals 3 healing groups
Vitalist	Color therapy, diet, herbs, hydrotherapy, homeopathic remedies, rhythm, shiatsu; individual healing	Homeopath, macrobiotic practitioners, masseurs, movement therapists, naturopath	8 individuals
Orthodox Religious	Pastoral counselling, prayer; individual healing	Standard denominations	undetermined
Technical	Bioenergetics, diet, hypnotherapy, Laetrile, massage, reflexology, scientology, visualization; individual healing	Hypnotherapists, masseurs, reflexologists, scientologists, unorthodox physicians	13 individuals 2 groups

by a circle (O), has a constant presence in all of the categories of healing except the most secular (Type VII). In this respect, the major distinction between categories is the quality of the higher power's presence. At one extreme, Type I, the higher power is most concrete and His presence is most tangible. The higher the number of the category, as will be detailed in the forthcoming pages, the less well defined this presence is. At the other extreme, Type VII, there is no belief in the healing presence of a higher power at all. The other distinction between categories is a function of the relative importance (symbolized by the size of the figures in Chart 4A) of the higher power, the patient, and the healer, in the healing process. Note that on the chart, the higher power's importance is constant for all but type VII. On the other hand, the healer, symbolized by a square (□), assumes progressive importance from I to VII (VI as will be explained is an exception). Finally, although not clear cut, the patient, symbolized by a triangle (Δ), tends to assume greater importance in the middle categories of the spectrum.

Throughout the text, healing philosophies are symbolized by a combination of a circle, square and triangle (O□Δ) except in the case of the Technical philosophy, which considers only the healer and patient □Δ. Whenever the philosophically ideal social relationship of a patient and any type of healer is referred to a hatched square and a triangle are used (▨ △). The actual healer-patient relationship is symbolized by a filled square and triangle (■ ▲).

One further aspect of the classification is that knowledge of a healer's healing philosophy allows the prediction of his/her interaction with orthodox medicine. In Wardwell's (1972) structural classification of healing arts, he notes that quasi-practitioners (Groups I, II, III, IV in my classification) offer healing theories and practices which are on an entirely different level than those of scientific medicine. They are not in any way meant to supplant the scientific model and its therapies. Consequently, these practitioners historically have generally had cordial and sometimes working relationships with physicians (Carlova 1973). On the other hand, marginal practitioners (Groups V and VII of the healing spectrum) usually base their practice on a "pseudo-scientific" theory of disease which is in direct conflict with that of medical science. Needless to say, these groups have not gotten along well with organized medicine. Derided as quacks, they are consistently being purged by medicine and its legislative lobbyists. A further distinction, as documented by the field data to follow, is that the quasi-practitioners usually offer their services without cost, whereas marginal practitioners expect pecuniary compensation.

The major advantage of using the Spectrum of Healing Philosophies as a system of classification is that (1) it is based on practitioner's belief systems and (2) it affords insight into important characteristics of the healer-patient relationship, e.g. perceived locus of control in the relationship. Both of these

factors are thought to be important in understanding illness behavior (cf. Chapter 2).

#### THE HEALING SPECTRUM

##### Fundamentalist (Type I)

The Fundamentalist believes that God is a personal being whose power is necessary and often sufficient for healing to occur. Neither the healer nor the patient are thought to play important roles. The healer is but a channel for the power of God. His/her function is merely to tap and direct this power. The patient is literally at the mercy of God. Perhaps because the healer considers his/her abilities to be a divine gift which s/he in no sense owns, only donations to the church may be accepted for healing services.

The Fundamentalist's preparation for his/her work is based on divine inspiration. If functioning independently of a congregation, the healer may have had no more "training" than a revelation that s/he was able to tap God's healing power. Otherwise, the Fundamentalist pastor will have received the basic training peculiar to his/her sect.

Fundamentalist healers are usually called faith healers, although the patient's faith is not necessarily a prerequisite to Fundamentalist healing.<sup>2</sup> Respondents were exasperatingly vague on this point. Faith in God is certainly the prescribed way to health, but it was admitted that, at times, the faithful are not cured and that the unfaithful recover. Perhaps this matter is best clarified

by the statement made by many Fundamentalists that healing is not strictly a matter of eliminating a disease. Instead, it is an acceptance of God's will. Rather than pray for recovery per se, a healer said, "We pray that God's will be done." Thus, one can die from cancer and nevertheless be healed if one has accepted this fate as God's will. In contrast, one may recover, but not be healed. "Healing" therefore means "reconciled to God."

Illness is usually considered to be largely spiritual-psycho-somatic, or as one person stated, "Disease is secondary to an imbalance in the expression of the soul-mind-body progression. Over-time this imbalance creates disease if not corrected." Other Fundamentalists are not so elaborate in their thinking and simply ascribe disease to God's will. Whether one leads a sinful or righteous life has some bearing on whether illness will affect a given person, but ultimately such things are unpredictable.<sup>3</sup>

Although the great majority of illness is considered to have a spiritual basis and can be treated with resort only to Fundamentalist healing practices, other illness thought to have a more purely physical basis, eg. acute trauma, necessitates the concomittant use of scientific medicine. All Fundamentalists in this study acknowledged the appropriateness of scientific medicine for some problems. In these cases, faith healing would be used in conjunction with scientific medicine. Further, God was thought to work through physicians. Only when Fundamentalists have refused or delayed

medical services deemed necessary by attending physicians have the two different healing arts clashed, eg. Jehovah's Witnesses and blood transfusions.

A number of methods are employed by these healers, eg. prayer, laying on of hands, ritual, song, Logos therapy (reading the Holy word). The main rationale behind the healing activities was described by one healer as an attempt to attract the attention of God. God cannot be manipulated, but various actions may increase the supplicant's chance of being blessed with His benevolence. Thus prayer for example presents the opportunity for praise and thanks. Said a faith healer, "Even God likes to be praised you know." The various healing activities can be performed alone by the patient, in the presence of a healer, or most commonly, with an entire congregation of people. Of note is that the patient need not be present at, or knowledgeable of, or consenting to a healing service for healing to occur. This type of healing is called absent healing.

#### Healers Identified

The healer is not always clearly identifiable as one person. Frequently, a congregation or simply a healing group takes active part as a whole in the healing process. Nevertheless, there was, in my experience, always a leader of such a group.

In Greater Erehwon, 8 churches with middle and upper class membership practice Fundamentalist healing. This includes Seventh Day Adventist, Assemblies of God, a Church of Latter Day Saints and

one other non-denominational church. These churches have sessions specifically devoted to healing services, as well as pastors who heal on a more individualized basis. Also identified were 1 faith healer (cf. Chapter 5) and 2 healing groups that were independent of churches.

Both healing groups were interesting in that they formed around an individual who had reportedly had a miraculous healing. The groups were inter-denominational. One group had an essentially stable membership of 15-20 people that met regularly in one of the member's homes. The other group was well-established in a large building that was termed a Faith Renewal Center. The leader of the group lived in the center and provided residential space for women who dedicated all of their time to the broader evangelistic activities of the center. Aside from the core group, members would usually participate for a defined period of time during which they were taught Fundamentalist healing principles. In general, the members of both healing groups were seeking their own spiritual and physical health more than working for the improved health of others.

#### Charismatic (Type II)

Charismatics trace their beliefs to the miraculous events, recounted in the New Testament (Acts 2), that took place on the fiftieth day after Christ's Resurrection - Pentecost Sunday, when the spirit of Christ came among His followers.<sup>4</sup>

"Charisma" is taken from the Greek root, "charis," which means grace. Among charismatic beliefs is that through God's grace, all Christians have been granted access to divine healing power. In contrast to the Fundamentalist, the Charismatic believes that though God's spirit, through Jesus Christ, is the healer, the patient must be prepared to accept Him into his/her life in order for healing to occur. In Charismatic healing, though the healer is still simply a channel for a higher healing power, s/he takes an active part in these preparations. It is as if the Charismatic healer must plow the ground before the seed is sown. Further, the seed will take hold only in the fertile ground of the patient's faith.

Regarding the healer's preparation, a Charismatic said, "I don't want to be called a healer. God is the healer. I take exception with the label "professional." It's a calling not a profession. You couldn't go to school to learn what I know. It would have to be conveyed on a disciple basis." Not surprisingly, direct payment is, as with the Fundamentalist, not accepted for the healer's services.

Illness is thought to have a spiritual basis. "Our well-being ultimately has to do with our relationship to God." Treating an illness, then, "first requires a 'diagnosis' of how people are relating to God."

Charismatic, like Fundamentalist, healing differs from the biomedical approach in that the aim is not simply to cure a disease

or eliminate a symptom. Rather, as a Charismatic stated, "The end of Christian healing is that a person be brought closer to Jesus Christ and God." No promises are made that a cure will be effected because "God hasn't promised this."

All types of problems may be tackled but the focus is on medically "hopeless" cases, spiritual-psycho-somatic illnesses, and preventive care. Total cooperation with scientific medicine is the rule. Indeed, nearly half of the membership of one Charismatic therapeutic community in Erehwon consists of health professionals.

The techniques used in healing reflect the fact that neither a healer nor even a group leader is always easily identifiable. As will be remembered, the founding belief of the Charismatic is that all Christians have access to the Divine healing power. One Charismatic group in New Erehwon functions as a true Christian commune. As an epitome of the concept of a therapeutic community, this group actually incorporates ill people into its midst. Another technique, intercessory prayer, is central to most healing services. People in the healing group pray for sick friends. As a Charismatic said, however, "It is not just a matter of sitting in a circle mentioning people's names. Jesus calls us to lay down our lives for others." Group song, laying on of hands, use of healing symbols (eg. the cross), and individual counselling round out the more common practices.

Healers Identified

It is difficult to quantify the number of Charismatic healers per se, because so often it is more appropriate to think of the group as being the healer. "Patient-healers" is an unimaginative term, but perhaps it best describes the reality. In any case, the Charismatic revival is burgeoning in Greater Erehwon. Episcopalian clergy, who have traditionally been trained in the healing unctions as one of the seven sacraments, are especially active in the area.

Some are members of the local chapter of the Order of St. Luke the Physician - a group which evolved from the Episcopal Church, but is now multidenominational with both lay and clergy membership.

Other Episcopal priests have revived the healing unctions as part of the regular church service or have special separate healing services.

Coverage by local press has expanded the number of participants in one of the healing services in town by many fold. This particular Episcopal, weekly, healing service has a congregation of patient-healers that ranges from 30-100. In all, 8 churches were identified as having Charismatic healing services. Three healing, prayer groups are known to have been organized by individual members of the Order of St. Luke. Four Chaplains of the Order, who are based in Erehwon, travel widely throughout the state on their healing mission.

A Charismatic therapeutic community of about 20 people has already been mentioned. Finally, one man that I met has worked as a freelance Charismatic healer since his retirement. He travels to several

churches in the area to assist in healing services by laying-on-hands and praying. He also works independently of the churches by making house calls on request.

#### Perfectionist (Type III)

The Perfectionists consist of a widely diverse group of healers who nevertheless share the common philosophy that disease, like other material things, is not real. Accordingly, healing is a function of the patient fully realizing the illusory quality of his/her illness by identification with the "Divine Mind." A Christian Scientist quoted from *Science and Health*,

"It was the divine law of Life and Love, unfolding to me the demonstrable fact that matter possesses neither sensation nor life; that human experience show the falsity of all material things; and that immortal cravings, 'the price of learning love,' establish the truism that the only suffering is the mortal mind, for the divine Mind cannot suffer."

He continued,

"the opposite of Truth, - called error, sin, sickness, disease, death, is the false testimony of false material sense, of mind in matter; that this false sense evolves, in belief, a subjective state of mortal mind which this same so-called mind names matter, thereby shutting out the true sense of spirit."

A Perfectionist Sikh said, "Perfect health is possible. Identification with the soul within and without you ends disease." Total healing, physical, mental and spiritual is expected. When healing does not occur, the patient blames not the religion, but his/her own spiritual inadequacies.

For the Perfectionists, medical problems have a spiritual genesis and can ultimately only be solved through spiritual growth. If all spiritual ministrations have failed and a Perfectionist is convinced that his/her patient's weakness of faith will prevent spiritual healing, s/he may recommend a physician as a last resort. Some surgical problems (traumatic or mechanically caused) are not thought to be caused spiritually, and are also thought to be best treated by a physician.

Although the Higher Power is conceptualized differently by different Perfectionists, its role in healing is similar. It is more passive than the Fundamentalist or Charismatic Higher Power. The patient shares equal responsibility in the healing process. S/he must go halfway in meeting the spiritual power. Because of the inevitable weakness of humans, however, a healer (Christian Science practitioner or Master) is sometimes needed. The techniques vary with the religious sect, but essentially the role of the healer is not so much to heal as to help place the patient on the proper spiritual path which will lead to identity with the Divine healing power. In this case, the healer's responsibility is not as great as the patient's. Christian Science practitioners, for example, will use primarily Logos therapy (reading the word) and prayer to restore a person's faith in his/her perfect health. The patient will also be expected to pray and read the Bible and writings of Mary Baker Eddy on their own. Sikhs use a wide assortment of techniques acting

on many different levels but all with the aim of bringing the patient closer to God: eg. dietary manipulation, yoga, chanting the name of the Lord, meditation, prayer, rituals and symbols.

Each Perfectionist sect has its own particular hierarchy of "healers." The Eastern sects require considerable periods of training - mostly as a disciple of a more spiritually evolved person. Spiritual advancement is not something that can be pursued, but something that comes. Advanced members of Eastern sects are healers in the broadest sense of the term - they are sages experienced in the problems of living. As with Type I and II healers, community healing is frequently emphasized, eg. the group vibrations of chanting, communal living, group healing ceremonies.

Christian Science offers virtually anyone the opportunity to enter its healing ministry by taking classes. To progress as a healer, however, certain spiritual experiences and insights are prerequisites. These practitioners function more like physicians in terms of their one-to-one relationship with patients. They also charge for their services.

#### Healers Identified

At least seven Christian Science practitioners, one group of Sikhs (10 adults at last count, cf. Chapter 6), and a group representative of the New Thought religious movement (The Unity School of Christianity) are active in the Erehwon area.

### Spiritual (Type IV)

Healers in this category vary in their conceptions of a higher power, but all believe that this, usually quasi-religious, power can in one way or another be manipulated for healing purposes. Psychics think in terms of vaguely defined universal energies, whereas mediums and spiritualists think more concretely in terms of personal spirits. All Type IV healers are similar, however, in that they believe that the higher energies can be controlled.

Illness is a function of psychic (or spiritual) imbalances which can be righted by tapping universal or spiritual energies. Total healing involves the correction of these imbalances and not simply the successful treatment of symptoms. Healing requires the active cooperation of the patient and the higher energy. Both may be thought of as having equal, though different, roles. The spirit is the power, but the patient provides the structure. The healer is but the channel (medium) for the healing power. The healer is uniquely valued because of his/her psychic (spiritual) capabilities which enable him/her to channel the power. Although it is thought that these capabilities are skills that can be purposefully developed, the healers generally believe that they have some kind of special innate gift. Most Spiritual healers are self-trained, though in some cases they have trained with other psychics or mediums. Generally, they don't expect to be paid for healing, but do obtain compensation for other related services, eg. psychic readings.

Many different techniques of healing are used and always with the expectation that the patient him/herself has a number of tasks to perform, eg. dietary manipulation, psychic development, etc. The psychic may diagnose problems by seeing or "combing" (feeling) auras (energy/light fields) around people. Psychic readings, i.e. a reading of a person's personal and collective unconscious, combined with an eclectic group of occult diagnostic sciences (eg. astrology, palmistry, graphology) also contribute to the psychic's understanding of a problem. Such "diagnoses" may or may not be used in the healing regimens. The psychics main therapeutic modality is transmitting "universal energy" to the patient. Color therapy (cf. Chapter 7) and meditation are skills sometimes taught the patient.

Type IV healers treat the entire spectrum of spiritual, psychological and somatic problems (excluding trauma). In general, these healers advocate that patients seek scientific medical care concurrently with the use of a Spiritual healer.

#### Healers Identified

Greater Erehwon is the home of a flourishing psychic movement. A great number of people claim psychic healing abilities, although few of them practice beyond a circle of friends. In Erehwon, there are three groups of psychics that function as schools and/or "research institutes" of psychic healing. Each school publicizes its events widely. One psychic group claimed to have graduated

1000 "healers" in the last three years. I saw no documentation of this figure, but did note that 60 students were currently enrolled at the time and close to 100 people were on waiting lists for instruction. This same institute had three separate healing groups of approximately 10 people. Each group met weekly to "send healing energy" to ill friends. Aside from the groups involved in the 3 schools, 13 individuals were particularly prominent as psychic healers in the community. Of special interest were 3 healers who practiced in the local medical center's hospital. One was a registered nurse, another a hospital chaplain, and the third a volunteer. One group of 2 psychics worked along with a Technical healer (cf. Chapter 9) in a large facility with the capacity for both in-patient and out-patient treatments.

There were no true Old Yankee Spiritualists (Macklin 1976) identified in the Greater Erehwon area. Nonetheless 3 people considered themselves mediums. They functioned as healers by going into a trance state. Either they would communicate with an omniscient physician spirit who would relay to the patient specific treatment regimens - usually consisting of herbs and special foods - or they would "work" (i.e. manipulate) spirits (often a deceased significant other of the patient) to clear the basic spiritual cause of the patient's problem.

### Vitalist (Type V)

Vitalists believe that Nature is the great Healer and place all their faith in the body's inherent natural healing powers. None of their therapeutic techniques are meant in themselves to be curative, but rather are assumed to stimulate a person's natural healing powers.

Disease is the result of violating one of nature's laws in thinking, breathing, eating, drinking, working, resting, etc. Each school of Vitalists, eg. naturopaths, homeopaths, macrobiotics, has their own particular versions of the natural laws, but all of these practitioners share a belief in a vitalistic force which is both within and without a person. The Vitalist, believes that healing involves more than the elimination of a disease. In particular, it consists of a total re-orientation in one's life style. Anything less guarantees the return of disease in one form or another.

As with the Spiritual healing philosophy, the Vitalist philosophy maintains that the patient and the Higher Power (Nature, Chi, etc.) share equal responsibility in the healing process. A number of elements of Vitalist beliefs, however, distinguish them from those of the Spiritual Healer. The Spiritual universal energies are powerful forces which a person can tap to be healed, but which can also overwhelm. In contrast, Vitalist forces are gentle. As Lao-Tzu said "Nature does not insist." For a person to be healed, s/he must simply recognize Nature's way and follow it - stop swimming against the current and float with it. The Vitalist philosophy also is more

clearly secular than the previously discussed types. It is more in line with some of the great natural philosophies of early Western and Eastern civilization. Finally, the role of the healer has become more important in this category than those previously discussed.

See Chart 4A. There is little sense of any divine calling or gift of healing beyond the special sensitivities of a healer for his/her fellow humans. Rather, more importance is ascribed to the skills that a practitioner can learn in his/her formal training. Further, the Vitalist is no longer a channel for healing energies. S/he has taken on his/her own separate value as a person skilled in invigorating a patient's healing powers. Nonetheless, as noted in Chart 4A, the healer is still less important than either the patient or the Higher Power in healing.

Among the Vitalist practitioners a formidable assortment of healing techniques and methods of diagnosis were used including: homeopathic remedies, herbs, hydrotherapy, dietary manipulation, acupressure, iridology, physiognomy, palmistry, musical rhythm, dance and shiatsu. All Vitalists identified charged for their services.

In general all of these practitioners felt that biomedical therapies and diagnostic techniques were heavy-handed and inappropriate, except as a last resort after more natural approaches had been exhausted. In such cases, however, these healers stated that they would readily refer their patients to orthodox physicians. The Vitalist practitioners were anxious for recognition and acceptance

by the medical profession. The people involved in macrobiotics were particularly active in this regard. Within 6 months of having moved to town, they had sponsored a conference whose theme was the integration of eastern and western approaches to cancer. A prominent academic oncologist was enlisted as a panel member for the conference.

#### Healers Identified

Homeopaths, naturopaths, macrobiotics, acupuncturists, movement therapists and some kinds of massage therapists can be classified in this category. In the Greater Erehwon area, one homeopath, one naturopath, two people active in macrobiotics and a wide variety of oriental healing techniques, a movement therapist, and three masseuses using an eclectic combination of Western and Eastern techniques were identified. The macrobiotic practitioners were highly visible in the community and advertised heavily, not only for their healing practices, but also for courses in natural healing, macrobiotics and herbal medicine.

#### Religious Orthodox (Type VI)

Orthodox clergy believe that the Spirit is present in healing, but need not be specifically invoked. Although spiritual words and practices may be used, the Spirit's healing power is mainly effective through the skilled techniques of the physician and counsellor. The clergy person is likely to believe that healing must occur on spiritual, emotional, and physical levels. S/he however,

defers any responsibility for physical healing to the medical professionals and restricts his/her role to spiritual counselling and emotional support. The clergy recognizes a spiritual force motivating the therapeutic actions of the doctor. In most other ways, the Orthodox Religious healing philosophy cannot really be distinguished from that of the orthodox physician. Indeed, there are many physicians who believe that God is behind their actions in some vague sort of way. In their healing capacity, the orthodox clergy really serve as ancillary professionals in the medical team captained by a doctor. Orthodox clergy do not consider themselves as healers in the sense defined in this study. Their healing philosophy is included here only to complete the dimension of spiritual involvement in healing. Otherwise, their practices have not been investigated.

#### Technical (Type VII)

Practitioners of this group represent a multitude of different healing arts ranging from chiropractors and scientologists to orthodox physicians. Their healing philosophies are however essentially the same in that uniformly, the Technical healer tends to emphasize the appropriate application of a particular technique as the primary ingredient in the healing process. No general statement can be made about their beliefs regarding illness causation - they are different for each sub-group within this category. Some have unicausal theories of disease and therapies, eg. "straight" chiropractors, whereas others believe in multiple causation, eg. orthodox physicians. Some practitioners

have a holistic approach to patients, i.e. they are concerned with body, mind, and spirit, whereas other focus on a particular type of illness or part of a person. Needless to say, there is also little agreement among the practitioners about what recovery is, eg. total healing of a person, curing of a disease, elimination of symptoms. Seemingly this diverse lot of healers has little in common.

Yet, philosophically many commonalities exist. There is no belief in spiritual factors that cause illness and no invocation of a spirit in healing. In all cases, whether the healer or patient is ultimately more responsible for actually effecting a treatment, eg. surgery versus taking a pill or following a diet, it is the external agent, i.e. the technique, that is credited with the primary power of healing. It is the skill and knowledge that a Technical healer has learned through a more or less rigorous training process that enables him/her to recommend and implement the appropriate technique. As an expert, then, the Technical healer considers him/herself relatively more important in the healing process than the patient, who implicitly is considered less competent.

Technical healers use an incredible assortment of techniques in their healing practices. Some healers like hypnotherapists, have only one basic technique, whereas others like physicians, employ many. Methods used by unorthodox Technical healers in Greater Erehwon include bioenergetics, biofeedback, dienetics, enzyme therapies, herbology, hypnosis, megavitamins, nutritional supplements, dietary

manipulation, laetrile, massage, and positive thinking. Many therapists use oriental healing techniques eg. Hatha yoga, reflexology, in a non-vitalist, Technical way.

Some Technical practitioners are philosophically opposed to a patient using the techniques of a different practitioner. Medical doctors are most outspoken on this point. Most of the non-medical Technical practitioners are more eclectic in their beliefs about which techniques are efficacious. Indeed, the Technical healers almost uniformly believe that a patient should have the right to use a wide variety of techniques. They thought, however, that orthodox medicine is invasive and dangerous and should be reserved as a last resort.

#### Healers Identified

For reasons already mentioned, chiropractors were not included in this survey. Also not studied were what Wardwell (1972) calls "limited practitioners," those practitioners who are legally licensed to use medical and surgical techniques on limited parts of the body, eg. podiatrists, hypertrichologists (removers of excess hair). Nevertheless, an ample number of prominent technical healers were identified. Two chiropractic physicians are mentioned because of their prominence in the community for using unorthodox non-chiropractic techniques, eg. reflexology, herbology. One of these healers conducted weekly public courses in acu-therapy, pressure points and reflexology.

Four medical doctors (not including the homeopath in Type V) were also well known in the community for their use of healing methods that went beyond the bounds of orthodox practice, eg. bioenergetics, unorthodox dietary manipulation. One group of 7 scientologists was identified, who, using dianetics, worked on patients' minds to relieve psychosomatic ills. One practitioner of what he called "synergistic healing" was discovered. His work incorporated many techniques, eg. diet, yoga, silva mind control, massage, hypnosis. Also enumerated were 2 masseuses.

Dietary therapy appears to be the most widely practiced unorthodox technique in Greater Erehwon. One man has practiced in his health food store in the same neighborhood for over 25 years. He helps people with serious, usually chronic, illnesses by suggesting dietary supplements and changes. He also refers people with intractable problems to the nutritional therapist discussed in Chapter 9 for more intensive (sometimes in-patient) treatment. Another natural food store carries over 100 different herbs from which a salesperson can recommend herbal infusions or topical applications for her sick clientele. There is also a nearby chapter of a national nutritional association which occasionally meets in Greater Erehwon. Meetings are devoted to testimonials about healings and discussion of a wide variety of unorthodox healing techniques with particular emphasis on dietary approaches.

Few healers were allegedly practicing illegally,<sup>5</sup> eg. nutritional and laetrile therapist (cf. Chapter 9), 2 people in two different health food stores who were prescribing herbs, foods and dietary supplements for the amelioration of illness. One hypnotist who was treating medical problems without medical supervision, told me that he had circumvented legal issues by calling his practices pastoral hypnotherapy and having his office legally defined as a church.

#### CONCLUSIONS

In the course of the initial field work, a number of impressions emerged that bear on both the actual prevalence of unorthodox healers and patients and their classification. After reviewing these points, the value and limitations of the taxonomy of healers is discussed.

#### Prevalence of Unorthodox Healers and Patients

The initial phase of field research has served to define the spectrum of healing practitioners consulted by middle and upper class people. Estimates regarding the actual number of unorthodox healers in Greater Erehwon must be made cautiously. A minimum number have been cited. Statistical inferences regarding the utilization rate of these practitioners by middle and upper class people cannot be made from the collected data. Subjectively however, a rough summation of the patient loads of the healers identified suggests that at least a sizeable minority of these people use unorthodox care.

The various types of healers documented as practicing in the Erehwon areas has probably been affected by its unique characteristics. For example, no domiciliary midwives are known to practice in Erehwon, although they practice in cities and towns throughout the rest of the state (Branham 1977). Possible explanations include: First, staff, policy at the local, academic center penalizes orthodox medical backup of homebirths, as might be supervised by a lay midwife, with loss of staff privileges. Second, professional nurse midwives are readily available in town.

Few illegal practitioners have been identified. Probably few exist, but those that do would most likely be unwilling to make their practices well known. On the other hand, a multitude of psychic healers have been documented as practicing in the study area. I suspect that this preponderance of psychic healers reflects their true numerical dominance in the field. On the other hand, the numbers identified may be inflated in relation to unlicensed Technical healers because psychic healers can practice and advertise openly without fear of legal recriminations.

Even if the healers enumerated in this study constituted all of the healers practicing in Greater Erehwon, there is good reason to believe that this number could not encompass the totality of healers used by middle and upper class residents of the area. In the first place, the number of people studying various forms of healing in classroom settings (eg. the psychic healing schools) suggest that the number of healers in Erehwon is growing. Secondly,

to limit the scope of my research, the study area was defined as the Greater Erehwon Area. For the primary purpose of my work, this definition was perfectly adequate. However, for the purpose of estimating the prevalence of unorthodox healers and patients, this geographic circumscription drastically underestimates the mobility of healers and patients in seeking each other out. Outlying suburbs, as well as cities thousands of miles away served as important points of origin and destination for peripatetic healers and patients.

Numerous contacts, living in the study area, told me of frequenting healers who practiced just outside of Greater Erehwon. For example, a prominent naturopath, an acupuncture clinic, several psychic healers and mediums in neighboring suburbs drew people from Erehwon. Two exorcists of international prominence were occasionally consulted by Erehwon residents. So too, some people travelled two hours to a far corner of the state to use a health clinic supervised by two unorthodox medical doctors. Also, I talked with an occasional person who had travelled thousands of miles in North American in a search for health. Some well-known healers in Erehwon reported that some of their patients had travelled from as far.

Not only did patients travel, but so did healers. For example, although New Erehwon had no resident acupuncturist, one from a nearby major city made house calls to a patient in New Erehwon. Occasionally, nationally known psychic healers came to the area and held large healing sessions. Another important type of "consultation" was the

healer who used the media to reach people. For example, a local television station carried a regular weekly show co-sponsored by the National Foods Association, The American Chiropractic Association and a California University. The show was called "Viewpoints on Nutrition" and was delivered by a chiropractor. Similarly, a radio station broadcast a nightly show featuring a prominent national unorthodox nutritionist and naturopath. Yet one other way of healers reaching people at a distance was through audiotapes. For example, a number of cancer patients told me that they used the Simontons' tapes - tapes which instruct the patient in how to visualize his/her white blood cells destroying the cancer.

Besides the geographic restriction, other aspects of the definition of the scope of this work have ramifications regarding considerations of unorthodox illness behavior. In the first place, undoubtedly a number of unorthodox self-care practices exist, eg. self-medication, acupressure etc. Secondly, an untold number of people consult "friend healers" whose advice or treatment may be unorthodox. For example, a graduate of a psychic healing course may practice on his friends. None of these friend healers were enumerated. Still more practitioners in Erehwon were not enumerated because they devoted their efforts solely to maintaining and promoting people's health. Such "health" practitioners included color and rhythm therapists, yoga teachers, movement therapists, etc. To totally disregard the relevance of these health practitioners to illness behavior is to

forget that most people begin doing something about their health when they feel something is wrong (Zola 1972). Lastly, a large group of unorthodox healers that must be remembered, although not included within the scope of this research, include the multitude of unorthodox healers whose practices are limited to emotional or spiritual problems or social classes IV and V.

#### The Value of the System of Categorization

The system of classifying healers presented in this chapter was created because existing systems were of little help in understanding why people choose particular laternative forms of healing. Based on a review of the literature, the assumption has been made that beliefs regarding healing may be a critical variable in the study of unorthodox illness behavior. The distinction of healers by healing philosophy facilitates an examination of the relevance of this factor.

Other potentially relevant variables will be shown to be associated with healing philosophy. The possibility arises, for example, that a healer's perception of the relative importance of higher power, healer and patient in the healing process may be related to the locus of control in the actual healer-patient relationship. In Chapter 10, data collected from the 5 subject healers will be used in the elaboration of a theory which links types of healer-patient relationships to healing philosophies. At the same time, the close correspondence of a healer's healing philosophy to his/her

conceptions of disease, treatment and cure will be delineated.

Certain personal qualities of the healer will also be seen to be related to his/her healing philosophy.

#### The Limitations of the System of Classification

The philosophical distinctions used to differentiate healers have been based primarily on what practitioners serving middle and upper class people in the Greater Erehwon Area have told me, rather than on scholarly accounts of healing philosophies prevalent throughout the country. It is possible that the taxonomy of healers derived from my field work does not encompass the full spectrum of healing philosophies extant in this country - especially among the lower classes. Even if the spectrum has been encompassed, the specific categories may not be appropriate outside of Erehwon.

By lumping such diverse healers as physicians, herbalists and hypnotherapists in one category, many differences are overlooked. Clearly, it must be remembered that this system of classification is most appropriately applied to the specific purpose for which it was created - to facilitate an investigation of the choice of unorthodox health care. And, it must also be appreciated that healing philosophies are to be considered as only one of several potential factors affecting a person's illness behavior.

In some cases, the healer's perception of his/her role relative to a Higher Power and to the patient in the healing process may bear

little resemblance to the healer's actual behavior in the therapeutic interaction, or to the patient's perception of this social relationship. As will be discussed in Chapter 10, the healing beliefs of patient and healer strongly influence, but are not the sole determinants of, their relationship.

## SECTION II FOOTNOTES

### Chapter 4

<sup>1</sup>The description of Greater Erehwon is based on sociological work by Meyers and Bean (1968), Census of Population 1970, and an account in the World Book Encyclopedia (1976).

<sup>2</sup>Healers in other philosophical categories may also use faith healing, eg. the Charismatic healer. In other categories, however, patient faith is usually considered necessary.

<sup>3</sup>From a biomedical point of view some of the life style proscriptions of Fundamentalist sects could be considered preventive medicine, if not righteous living, eg. Seventh Day Adventists are vegetarians and prohibit drinking, smoking, and the use of stimulants.

<sup>4</sup>According to Pattison (1974), the contemporary Charismatic revival - a neo-Pentecostalism - is a widespread ecumenical movement growing largely from the conversion of Fundamentalists and those of fundamentalist persuasion in the mainline denominations.

<sup>5</sup>In the Connecticut General Statutes, Section 20-9 of Title 20, regarding Examining Boards and Professional Licenses, defines who may practice medicine or surgery:

"No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a certificate of registration as is provided in section 20-10, and then only in the kind or branch of practice stated in such certificate..."

Under these regulations only medical doctors, osteopaths, chiropractors and naturopaths can be licensed to practice in those ways restricted by their certificates of registration.

## SECTION II

### REFERENCES

#### Chapter 4

Branham T: Midwives. *New Haven Advocate*, April 6, 1977

Carlova J: Even M.D.'s have faith in this faith healer. *Medical Economics*. September 1973, 98-101

Census of Population, 1970, Volume 1, Characteristics of the Population, Part 1, Connecticut. Washington, D.C. United States Department of Commerce, Bureau of the Census

Macklin BJ: A Connecticut yankee in spirit land, Case Studies in Spirit Possession. Edited by V Crapanzano and V Garrison, New York, Wiley Interscience, 1976

Meyers JK and Bean LL: A Decade Later. New York, John Wiley and Sons, Inc., 1968

New Haven. *World Book Encyclopedia*, Vol. 14, Chicago, Field Enterprises Educational Corporation, pp. 194-195, 1976

Pattison EM: Ideological support for the marginal middle class: faith healing and glossolalia, *Religious Movements in Contemporary America*. Edited by II Zaretzky and MP Leone, Princeton, Princeton University Press, 418-455, 1974

Wardwell WI: Limited, marginal, and quasi-practitioners, *Handbook of Medical Sociology*. Edited by HE Freeman, S Levine, and L Reeder, Englewood Cliffs, New Jersey, Prentice-Hall, Inc. 250-273, 1972

Zola IK: Studying the decision to see a doctor. *Adv Psychosom Med*. 8: 216-236, 1972

SECTION III

CASE STUDIES: HEALERS AND THEIR PRACTICES

## OVERVIEW

This section will review the case studies of the five healers chosen for intensive investigation. In order to orient the reader to a healer's practice, each chapter begins with a brief description of the healer's principal techniques as they have been described in the literature. The interested reader will be referred to the appropriate references for further information. After this brief introduction, the healer's profile is presented, followed by a profile of his/her practice.

The main aim of these case studies is to know who a patient has decided to consult. The presumption is that who the healer is (i.e. what techniques s/he uses, what the organization of his/her practice is, what his/her healing philosophy is, etc.) is an important ingredient in the patient's choice of an unorthodox healer, and perhaps a variable in the decision to seek unorthodox care in the first place. The final chapter of this section reviews the case studies for themes which are relevant to the study of unorthodox illness behavior.

Using the HEALER SURVEY FORM (cf. METHODS, Chapter 3 and Appendix B), I was unable to obtain the complete cooperation of healers in the survey of their patient populations. Therefore, the section of each case study entitled, "The Day, The Patients", is not meant to be a statistically valid picture of the healers' practices. Instead, the HEALER SURVEY FORMS, as variably completed by healers, were used in combination with my personal observations to paint an impressionistic picture of the patient populations. The precise method of arriving at this portrayal is detailed in the appropriate section of each case study.

Note that each healer has been identified with a Roman Numeral corresponding with the category of healing that s/he

represents. This numeral should aid in identifying the patients of healers in later chapters. Also, each healer's relationship with his/her patients, as well as his/her healing philosophy, has been symbolized with the figures introduced in Chapter 4.

## CHAPTER 5

MR. JOSEPH CARBONELLA, FAITH HEALER

Fundamentalist (Type I)

## BACKGROUND

In a general sense, faith healing is founded on a belief in the healer's power to help an individual and/or a belief that a Higher Power wills the recovery. This healing practice is an ancient method that has been employed by healing places, such as the Lourdes shrine as well as by practitioners of a wide assortment of healing philosophies. In reviewing the taxonomy of healers identified in Greater Erehwon, for example, virtually all of the practitioners might be said to at least occasionally purposely use this technique. Indeed, it is the very basis of the power of the placebo. Even a Technical practitioner, like a medical doctor, recognizes the therapeutic significance of a patient's faith in the doctor and his/her techniques. (JAMA 1956)

Most commonly however, faith healing is associated with Types I-III practitioners. Some are affiliated with a particular Fundamentalist Church. Others act independently like Katherine Kuhlman, Olga Worrall, Oral Roberts. Charismatics, Christian Scientists, Jewish Scientists and Divine Scientists are healers of different philosophical categories who also practice faith healing. In all of these cases, it is believed that God is the healer.<sup>1</sup>

Joe Carbonella's personal healing philosophy is essentially Fundamentalist (Type I). Aside from the prerequisite criteria mentioned on page 28 he was selected for study because of his unique mode of practice. He practices clandestinely in a large academic teaching hospital.<sup>2</sup>

## PERSONAL PROFILE

Mr. Carbonella is a 57 year old, social class IV, married man of mixed Italian and Polish descent, with two grown children. Both his mother and father were immigrants to the United States before his birth. Born in a house in New

Erehwon, he has lived in this area all his life. He, his parents and his four brothers shared a house and one toilet with eleven other families in the toughest neighborhood in town.

As poor as his parents were, they were too proud to accept any handouts. By the time Mr. Carbonella had made it to 8th grade, he decided it was time to quit school to help make money for his family. Beginning as a manual laborer, he eventually was hired as a janitor in a local bank. The work of the bank's auditors fascinated him. Interested in improving his lot, he used to stay after hours to closely attend to their work. Ultimately, on the basis of his enthusiasm and quickness, he was given the opportunity to train as an auditor-- a career which he was to pursue for 24 years until he broke his back in an accident at the bank. That moment precipitated near disaster, and ultimately his career as a faith healer.

#### Beginning of Involvement in Unorthodox Healing

Although no one in his family had ever been involved in a healing profession, Mr. Carbonella had always wanted to be a doctor. The expense of medical school had prohibited the fruition of this desire. To him, his accident was a divine action to help him fulfill his life. He hated his job at the bank, but "didn't have the guts to quit. It took a major disability to get away. God knew best." His injury required surgery and he remembers vividly, "When I had my operation I cried all the way to the OR. A nurse held my hand all the way-- a 110 pound little nurse holding a big 200 pound elephant like me, that gave me such strength I'll never forget." He was told he would never walk again. Immobilized in a full body cast, he was unable to do anything for himself. His recovery was slow, beset with complications and plagued by a sense of social isolation and depression. "I was in bed for three and a half months in the hospital

and not one friend came to help me with a glass of water. I got loads of cards but I tore them all up. If they couldn't take 10 minutes to come and visit me, I didn't need their cards." Although he felt deserted by his friends and literally physically abused by his intern, he remembers his private doctor as being "fantastic".

Finally at home, the recovery dragged on. Immobilized, hoplessness set in. He spent days in bed crying. Three more months went by. His back had healed, but he was permanently disabled-- able to walk but not to work. After two years of psychotherapy, his emotional wounds were still raw. In a moment of despair, he set out in his car to drive off a cliff. His wife, worried and suspicious of his intentions, notified the police and somehow he was apprehended in time. Foiled in his dramatic plan, he decided "to join the Mafia, because I didn't want to live and I wanted to make my family a lot of money. I made all the connections and was about to go to \_\_\_\_\_. I was accepted as part of the Family. It was just then that I got the sign from God."

On the edge of this decision, he decided to give God a chance. A practicing Catholic, he had until this point only gone to church for holidays. On this day, he put his faith on the line. "I asked the Lord to either take me or cure me. I know I can't see you God, but I'm just asking for a sign that I'll get better. Or, I'll take my life today." Alone at midday, standing in front of the altar at a nearby Catholic church, he

stretched out my hands and cried, sitting in the in the first pew. All of a sudden a brown bird flew down and sat on the floor staring at me between the altar and me. I tried to scare it away, but it wouldn't leave. I broke out in a cold sweat and ran home. Beginning the next day I started back up the ladder.

Soon he was to take his psychiatrist's advice to vol-

unteer at a local hospital.

After patient aide training by Nursing In-Service, I started two mornings a week, first for my own satisfaction-- to get better myself. After the second week, something happened to me inside. By helping the patients, I was really helping myself. I was really needed. Others were depending on me. That's a wonderful thing to feel. I forgot about my own injury. It was the patient's need that became important. I added another morning, and then another and before I realized it, I was coming in every morning, seven mornings a week, at 6:30 a.m. And holidays too.

Seven years later, his schedule has not changed. Otherwise unemployed, he volunteers 5-6 hours every morning of the week, 52 weeks of the year. A skilled conversationalist, positive thinker, and ever helpful with the mundane nursing chores that most staff avoid, but which he knows from personal experience mean so much to patients, Mr. Carbonella has become the volunteer extraordinaire. His life is his work. Much respected and appreciated by patients and staff alike, he has been honored by membership on many hospital committees and by a special citation from the mayor of his town. Today Mr. Carbonella is an outgoing, ebullient, determined man who exudes personal strength. His tough exterior is no mask for what at once can be discerned as a man with a capacity for compassion and tenderness.

For the last five years, Mr. Carbonella has been something more than a patient aide volunteer. He has, unbeknownst to most of his colleagues and patients, worked as a faith healer. Initially disbelieving, he slowly was increasingly impressed that people left the hospital more quickly under his ministration.

After having worked for a couple of years and seeing the response I was getting, it made me feel that I was gifted-- that the Lord was giving me something for all that I went through.... I feel very strongly that He has picked me to serve the people.

Have you ever known any one to work 7 days a week without pay? It's got to be a gift.

Faith healing is not something that can be learned. "Not everyone can be a faith healer. Faith healing is just a gift, it's not (a matter of) training."

Mr. Carbonella feels that his success with patients and hospital staff is the result of the Lord working through him. His newly found interpersonal skills seem truly to surprise him. They seem somehow foreign to him. He does not own them; they are gifts. These skills are not, however, Mr. Carbonella's only signs that God works through him. He senses whether people are going to recover smoothly from an illness. "I'm not a psychic-- not one of those guys that can predict the future, but as for patients, I can read their face and know how things are going to be." Once a miracle occurred which, to Mr. Carbonella, confirmed his gift as a faith healer. Working with a patient that had a brain tumor and had been told she had no more than a couple of months to live, Mr. Carbonella prayed for a sign that she would get well. That same morning, while crossing the street to the hospital, he saw a blue light flash across the sky. That day was the turning point for his patient. Now almost three years later, Mr. Carbonella says she is asymptomatic.

#### Religious Affiliations, Beliefs and Practices

As a Fundamentalist healer, Mr. Carbonella's religious beliefs have strongly affected his life as a healer. There had been nothing remarkable about his lackadasical practice of Catholicism, until the time of his back injury. Literally feeling reborn, Mr. Carbonella had much to praise the Lord for. As he became convinced of his gift of healing, he switched his religious affiliation from a relatively staid Catholic church to a church of the Assemblies of God, where glossalia and faith healing were assumed. Now he goes to

church twice during the week for healing services and three times on Sunday. He believes literally in the Bible and believes that its mere presence, let alone reading it, has a healing power. Not only are Mr. Carbonella's beliefs confirmed by his own miraculous experiences, but he believes that his wife also is infused with the Holy Spirit. In church she practices glossalia-- speaking in tongues. In keeping with his Fundamentalist beliefs, he believes in the concrete reality of such concepts as Hell, Heaven, a personal God, the Apocalypse and The Armageddon.

Whether or not people have control over the course of events is somewhat problematic for Mr. Carbonella. On one hand, he feels that it is "all in God's hands. We can't change the will of God. Prayer provides encouragement, the will to go on, but ultimately its up to him." On the other hand, Mr. Carbonella feels that people have to take an active role in life. It is as if God has the option of locking or unlocking the door, but if the door is unlocked, it is up to the person to walk through it.

#### Illness Beliefs

Recognizing a lack of relationship between illness and the kind of spiritual life one leads poses some problems for a religious man like Mr. Carbonella. Mr. Carbonella struggles in his understanding of why only one of two people exposed to the same risk factors may fall ill. He notes that "We all sin, but sin has nothing to do with our illness. Christ paid for our sins.... Illness is never sent as a punishment. God never meant for us to suffer." If a "patient asks me, 'Why me?', I tell them you can't ask that, there is no way of knowing. There is no answer to that. It happened." Sometimes Mr. Carbonella is more bothered by his difficulty in discerning a relationship between righteous living and good

health. Searching for an answer, he says, "some people get better in two days without praying. I don't know why. Maybe it's because they're so gifted. They've built up their religion or something so strong that they don't need to pray (This rationale is remarkably similar to the concept of karma)." An experience with one person, a diabetic who is losing a leg and going blind, upsets any pat rationalizations Mr. Carbonella might have about who illness affects. "I've known him since he was sick. He's always been a fantastic person. He doesn't deserve it. He has a right to be bitter. If I went through that, as religious as I am today, I think I might reject religion too." Note the ambiguities in Mr. Carbonella's thinking about illness. At one time, he denies any relationship between sin and sickness. Other times, he reveals a disillusionment in the lack of relationship between righteous living and good health.

In the end, Mr. Carbonella sometimes feels forced to conclude that "It's just bad luck that people get sick." In a more philosophical and characteristic vein, however, he is more apt to say that there is a purpose behind God's will. He cites his own illness as a case in point.

Although Mr. Carbonella cannot really pin down what illness is, he feels that "ninety percent of an illness is emotional. I know 'cause that's what it was like for me." Making the distinction between his disease (the organic problem) and his illness (his reaction to the disease), Mr. Carbonella says that it was not the injury or operation that was so troublesome, it was his reactive depression. "I was willing to go through the whole back operation again if it would've made the mental condition go away."

#### Conceptions Of Health

As do most lay people (Kasl and Cobb 1966), Mr. Carbonella defines health as a feeling state, freedom from physical symptoms,

and an ability to perform daily activities. Health is not fragile. One does not have to work constantly to maintain it, but one has to be mindful of such factors as diet and exercise. And, one can compensate for being born "with a pretty poor body, if you take care of yourself you can be pretty healthy." It is evident by his distinction between disease and illness and by his comments about healing that healing does not necessarily imply complete recovery from a disease, i.e. a return to good health. Rather, Mr. Carbonella sees healing as being primarily, though not completely, concerned with a return to emotional and spiritual health. Within limits, this kind of healing will spur physical recovery also.

#### Knowledge of and Attitudes Toward Scientific Medicine

Philosophically and practically, Mr. Carbonella has succeeded in creating a fine weave between his Fundamentalist healing philosophy and his work as a patient aide volunteer in a hospital. In his job as an "insider" in the medical system, he has come to respect and value the role of medical doctors in healing. He sees their medicines and surgery as important tools in aiding a person's recovery. He does, however, fault most doctors on their relationship with patients. Specifically, he feels that no matter how pressed a doctor may be for time, it is the physician's responsibility to spend time comforting a patient. "I don't feel the doctors and interns should just go in, give the medicine and then leave. It's important to go in and spend a few minutes talking. It would bring them (the patients) more quickly to recovery." Alluding to his special gift of making patients feel better, he notes that "If some of the doctors had gone through suffering like I did, they wouldn't be in such a hurry.... Most doctors are hard and swift. They speak by a time schedule." Explicitly, he is saying that medical training alone may not be sufficient to make a good healer. Rather, a more special type of preparation is needed also. In his healing practice, Mr. Carbonella

draws heavily on his extraordinary preparation. His experience has given him a model by which to treat people. "I don't treat people like a disease.... What I try to make people feel is that I care for them. So many doctors treat patients as if they were fitting a pair of shoes."

Working in the hospital has provided Mr. Carbonella with a knowledge of medical science that most unorthodox healers do not have. Especially facile in using the common orthopedic and neurosurgical terms relevant to the patients on his specialized ward, he is also relatively sophisticated in other areas of medicine. For example, he was able to cite the American Cancer Society's seven early warning signs of cancer-- and then some.<sup>3</sup>

#### Healing Beliefs

Mr. Carbonella's work as a patient aide volunteer puts him in extended, intimate contact with patients. The organization of his healing practice within this context is fascinating and will be thoroughly detailed later. Now however, one point is critical to understanding his healing beliefs.

A most remarkable aspect of his healing practice is that it is "undercover". He maintains that until the time that he met me, he had never told either the hospital staff or his patients of his work as a faith healer. (In fact, as will be pointed out on p.109, several key hospital staff as well as some of his patients know that he is a faith healer.) Mr. Carbonella feels his reputation is as a friend of the patient and that is the way he wants to keep it. He's afraid that if he were more open about faith healing in the hospital, he would be identified as a priest and not as a patient aide. He is afraid that religious overtones to his offers of friendship and service would close many doors.

As a patient aide volunteer, I have the freedom of the doorways. I'm no faith healer, priest, Rabbi, or whatever. If people knew I was a

faith healer, they'd say 'Oh God, here comes that quack the faith healer again!'. I don't want just 50 out of 100 patients. Look how the other 50 would lose out on me helping them with eating, walking, etc. I know I've been gifted and I don't want anyone to lose out.

On the surface, Mr. Carbonella's personal healing philosophy deviates somewhat from the ideal fundamentalist category. Although he has no doubt that God is the ultimate healer, that He works through doctors and through faith healers like himself, Mr. Carbonella places great emphasis on an active patient role. If it is God's will the patient may be healed, but only if s/he works for it. Mr. Carbonella's conception of the relationship of the parties involved in the healing is remarkably clear.

Medicines, doctors, and patients themselves (take part in the healing). I pray with them (the patients). If they refuse that, I pray for them and touch them. (He lays on hands without telling the patient what he is doing. (Actually, at least some of his patients do know what he is doing (cf. p. ). Healer and patient maintain what apparently is a tacit agreement not to openly discuss faith healing, see also pp. . In some cases, he does proclaim his intentions.) The faith healer helps in the continued well-being of the patient. The doctor takes out the tumor. How am I going to cure someone with a tumor. My job is to give people the confidence that they are going to be healed. It's not enough for people to pray. They must have faith in their prayer of healing. You can't just mumble and say Amen. You've got to demand your health from God-- the way I did for myself.... Grab the Lord and tell him what you want. You've (the patient) got to believe what you're praying for. If you don't, you won't recover.

Seemingly similar to my description of the Charismatic healing relationships, Mr. Carbonella's philosophy is betrayed as more truly Fundamentalist in his portrayal of God as a whimsical, aloof Almighty whose favor must be courted:

Faith healing works through the Lord. He's the only one to turn to. You (the patient) must ask Him for help. He's given us so much that we must seek Him out. Everyone likes praise. God likes a pat on the back now and then too.

The typically Fundamentalist quality (O<sub>Δ</sub>Δ) of Mr. Carbonella's healing philosophy becomes even clearer when he observes that

God heals sinners and non-sinners. He heals all, but we have to pray for it. How else are you going to get it. God doesn't heal everyone. He only heals the chosen. All we can do is keep praying, but if the person doesn't get better, its just the will of God. We can't change the will of God, but prayer provides encouragement, the will to go on. But ultimately its up to Him.

True to the Fundamentalist category, Mr. Carbonella also believes in miraculous healing with which neither the patient, the doctor nor the faith healer have anything to do with. It is rather a concrete manifestation of God's omnipotence.

Mr. Carbonella recognizes that "Faith healing doesn't work for everyone. Some people you can pray for for a hundred years and it won't do anything". So he does not "pray for every patient. I only pray for those that I am 'told' to. I don't feel for all of them. I have to feel it in my system. It's like receiving the Holy Spirit. Something comes across telling me I should pray for someone." Philosophically, Mr. Carbonella believes that if a person does not recover, "The Lord has picked them out for a better future in the new world." In this sense, healing involves helping a person accept his/her fate. To one man dying of cancer, Mr. Carbonella "gave as much love and attention as a brother. I told him about reading the Bible for strength. This man died in peace."

For Mr. Carbonella, the essential part of faith healing is maintaining a person's courage and strength. He doesn't "guarantee a cure. I can't do that." Hope (and healing) is not dependent on recovery, it is, rather, a sense of peace, acceptance of one's faith and maximum feasible control over one's daily routine and life.<sup>4</sup> Mr. Carbonella says he has "never seen anyone die in pain. Death is very peaceful." Witnessing his work with dying patients, I find this state-

ment difficult to accept at face value. Is he denying his daily experience? In this experience, he finds rationale for not telling people of his faith healing practices. "I don't call it faith healing to the patient, because supposing they don't get well overnight-- what would happen to their religion. You just tell them you're praying for them." I suspect that Mr. Carbonella's approach not only prevents his patients disillusionment, but also mollifies his own.

Consonant with his distinction between recovery and healing, Mr. Carbonella does not always pray for a person to get better. During my observation of his practice, Mr. Carbonella told me of one patient for whom "I put my hand on his leg everyday and pray that he dies. I say Lord, if there is no hope for this patient, please take him. I make very very sure that there is no hope. It's not easy to say that kind of prayer."

As to just how helpful Mr. Carbonella perceives he is in aiding the recovery of people, he has no question that he is "more helpful than doctors with anxiety, depression, loneliness, and in decreasing pain. These are the problems that can double an illness." Whether or not Mr. Carbonella can use faith healing to actually cure a disease like cancer is more problematic for him (though he cites cases where he believes his intervention has been key, cf. p.96). Similarly, he feels that medicines and surgery (as the tools of God) are more directly the cause of a person's recovery than his own ministrations. He is certain, however, that his practices effect a shortened recovery time and reduce the morbidity of an illness.<sup>5</sup> At any rate, what can be appreciated is that Mr. Carbonella sees that medicine and faith healing have complementary roles.

#### Healer-Patient Relationship: Expectations and Satisfactions

In general, Mr. Carbonella feels that patients look to him mainly for encouragement and strength. He feels "they

think I've been gifted, too, because of the problem (back injury) I had.... Some of them want sympathy or pity. I never give them that because that is not what they need. I give them love." Sometimes patients request that he teach them to cry. To help relieve his patients and his own feelings, Mr. Carbonella will cry with patients. His perception is, however, that his patients also "feel that Mr. Carbonella will help them physically, because they see what I've done. If he can do it, why can't I do it (i.e. recover from a serious illness with hard work and faith).

Mr. Carbonella suffers from ~~an~~ illusion concerning his place in a person's hierarchy of resort. Not only does he not expect or want to be a person's main source of health care, he supposes that he usually is their last resort. Once contact has been made in the hospital, however, he quickly becomes a more accessible and used source of care. While on the hospital ward, Mr. Carbonella is often called ad lib by his patients because the professional staff is not available. In fact, Mr. Carbonella feels that, to his patients, time is one of his most important assets. With this tool he is able to give them the moral support they need. From his perspective, however, his prayer is most important. And as for his other actions with patients, i.e. nursing chores-- they provide the opportunity for the Lord to work through him. In any case, he expects that his patients will be "cheerful, will listen to what I'm saying and have faith in me."

Mr. Carbonella finds that often there are other reasons behind the overt request for a visit. "So often they (patients) are afraid. They just want someone to come in and talk with them." Occasionally, too, he feels that patients are malinger. "We have them coming in sometimes just to collect insurance. If I feel that, I'll tell the doctor. Doctors sometimes ask me if I think that the patient is faking it. I don't like someone (a surgeon) to mess with his back just

for the money."

In general, however, Mr. Carbonella feels strongly about maintaining an absolute confidentiality regarding the personal interchanges between him and his patients. He only will break this confidence if in his opinion a patient is withholding information from the doctor that is critical to his/her medical treatment.

Mr. Carbonella readily points out that there is often conflict between what he wants to do with a patient and what the patient is receptive to. His solution is simple. When it is a matter of differences in religious beliefs, he overtly drops the subject. Nevertheless, he goes on with his "treatment". He prays for these patients on his own, and while praying, will lay his hand on patients with some other excuse for touching them. When a patient resists his advice to fight for his/her health, Mr. Carbonella will simply continue his gentle support all the while admonishing the patients that s/he must work to recover.

Mr. Carbonella feels that as a faith healer and patient aide volunteer, his relationship with patients not only should, but must be based on friendship. The chief characteristics of an ideal healer to Mr. Carbonella is that s/he cares. What pleases him most in this interaction is not merely helping the person get well, but also preventing a patient's depression and anxiety. His only dislike of this kind of work is that he cannot do enough. He never will refuse the requests of a patient, but will advise the patient not to seek surgical treatment when Mr. Carbonella feels, allegedly in concordance with the patient's physician, that surgery is not indicated.

#### PRACTICE PROFILE

Mr. Carbonella is based on an orthopedic and neurosurgical ward in a university affiliated hospital. In his role

of a volunteer he arrives every morning of the week at 6:30 to help with the unskilled nursing tasks for his ward's patients. Most of his 5-6 hour day is spent neatly weaving his patient aide and supportive functions with his faith healing practice. He feels most immediately responsible for all of the patients on his ward, but he does bi-weekly rounds of all hospital wards to check if there might be patients elsewhere in the hospital that staff feel might benefit from his supportive skills. He is also always ready to visit a patient by special request of a patient or staff person.

In spite of his impoverished financial state, Mr. Carbonella resists salaried hospital employment. For the few extra dollars employment might yield, he fears that the type of relationship he has with his patients would be seriously affected. Accordingly, all of his work is on a volunteer basis. He will not even accept gifts. All that he will take is a "God bless you" because he feels that can only increase his effectiveness.

Mr. Carbonella does most of his work by himself except when he is helping other hospital staff or when he is training patient aide volunteers. Aside from fellow church members, he has no contact with unorthodox healers.

#### The patients

Mr. Carbonella used faith healing for an average of 11 patients each day during 3 randomly sampled days in 3 separate weeks of the study.<sup>6</sup> (On a more mundane level, i.e. passing out food trays etc., he saw many more patients in a day.) They ranged in age from 18 to 74. Of the total of 33 patients seen, 30 were non-Hispanic whites. The remaining 3 were Black. About two thirds (21/33) of the patients were male. Mr. Carbonella was, by principle, opposed to asking a patient questions about his education and occupation so that the socio-economic distribution of his patients is not known.

Nonetheless, because he practices in a ward of the hospital where all patients have private physicians, it can be surmised that his practice is weighted toward the middle and upper social classes. Due to the nature of his hospital practice, Mr. Carbonella saw most of his patients many times. From day to day his patient population usually changed minimally. Mr. Carbonella had seen 22 of the 33 patients several times before during their current hospitalization. For all but 3 of the total number of patients, Mr. Carbonella had initiated the contact. One patient asked that Mr. Carbonella see another patient. A nurse asked him to see a patient. The third patient knew Mr. Carbonella from a previous hospitalization and asked the volunteer office that he be sent to her.

The medical problems that Mr. Carbonella's patients presented were as varied and complex as one might expect in a tertiary medical complex. Their usual complaints to him, however, were couched in simple terms. They complained most often of pain or fear. Although adapted to the needs of individuals, Mr. Carbonella's treatments were similar in their approach. He provided emotional support, performed small chores, prayed and laid on his hands. And, occasionally, he lied-- telling patients who were dying that they were doing better.

#### Observations of Practice

Mr. Carbonella's approach to patients varied with his perception of their needs. Sometimes he went no further than helping out with nursing chores. Other times he simply acted the part of a supportive friend. Usually when he felt that a person was receptive to building a relationship, he told the story of his own illness as a model for what a person can do if s/he has the will power and the faith. At this point, Mr. Carbonella would not raise further religious matters unless

he sensed that a person might be receptive to God. If he perceived that the person was receptive, he might read the Bible with the patient, pray with him/her, or deliver a little pep talk about the healing power of God. For the unreceptive person, he did not push his religious view. In these cases he would tell me later, "I'm not a fanatic on religion, but in between the 'Hello, how are you?', I'm saying (to myself) we're doomed unless we go back to God."

Mr. Carbonella will use faith healing in all cases where he feels it can be appropriately applied (p.102), regardless of his patient's religious or healing beliefs. To himself, he will pray for their healing while touching a shoulder or leg. For example, he "Always helps people on to the stretcher before the O.R. I'm there at the head part. look them in the eyes and help wiggle them over with my hands on their shoulders doing my faith healing." While in a patient room, he will find some excuse to touch the person for the purposes of faith healing. Cognizant of Mr. Carbonella's healing practice, I could discern a difference in the manner in which he touched people. When he was laying on his hands, he tended to firmly grasp a patient's leg, hand, or shoulder and gently shake the body part. Mr. Carbonella also prays at his church's healing services and at home for his patients.

An important part of Mr. Carbonella's healing philosophy, that a patient take an active role in his/her recovery is reflected in his healing practice. He concentrates in particular on the power of positive thinking. As he entered a patient's room, he would say, "Boy you look better today." The patient might say, "But I was sick to my stomach all night." He then would say, "Sure that's normal. You're in the hospital; you're sick, but you're looking better today."

Having once made contact with a patient, Mr. Carbonella never drops a relationship. At least once daily, he will take the time to talk with the person and to remember him/her in

his healing prayers. In fact, once the patient is discharged, he does not "drop the patient off as a patient, I follow him at home as a person." Using his own scarce funds, he will call every patient at least three times after his/her discharge and impresses on the patient that s/he can call anytime. To Mr. Carbonella, this "phone call to the patient is a very important thing. It gives encouragement, extra strength and a feeling that someone cares. And I can do faith healing over the phone."

#### Relationship with Patients

Observation of Mr. Carbonella's practice yielded one point of significant discrepancy from his beliefs and perceptions about his practice. The remarkable exception was that in spite of his remonstrances that he never disclosed his identity as a faith healer, his convictions wavered during my observations. Although not necessary for either ethical or research reasons, he, in my presence was effusive to the patients about his faith healing. He would say, "I've never told anyone this, but I'm a faith healer. I believe in faith healing." No one seemed to be particularly surprised or offended, at least in our presence. In later discussions with several of his patients (cf. p. ), I discovered that Mr. Carbonella had previously revealed his identity to some of his patients. These patients were as reluctant to admit this fact as their healer had been. I also discovered that several key hospital staff, including a top administrative official, a professor of medicine, the head of a department, a nursing supervisor, as well as a number of staff nurses. In fact, I discovered through a well placed hospital employee that all of these people would themselves clandestinely refer patients to Mr. Carbonella for the express purpose of faith healing. In sum, I got the impression that a network of people, staff, patients, and healer, were colluding to permit an unorthodox healing practice within an academic hospital. Furthermore, by refraining from using the term "faith healing",

many of these people with scientific background were able to participate in Mr. Carbonella's practice without as much cognitive dissonance.

#### IMPRESSIONS OF PRACTICE

Joe Carbonella is a man who believes he has been called to heal. His Fundamentalist philosophy of healing emerged from a dramatic spiritual experience. Working among sick people in a hospital setting led him to the slow realization of his healing gifts. Mr. Carbonella's healing practice is in many ways like Christ's. For example, there are resemblances to Jesus' unpremeditated healing. Even those patients who are unaware of his alleged healing gifts appreciate his "healing" presence, i.e., patients may actually seek the Lord's healing unintentionally by seeking Mr. Carbonella's "God-given" gifts, e.g., his interpersonal skills. The similarity to Jesus' vacillations in the New Testament about whether to call attention to His special gifts, as "proofs" of His power and divinity, is striking (Mark 5:1-20 versus Mark 5:21-43). In general, Mr. Carbonella's relationship with his patients (█▲) reflects his philosophy of healing (○▲). He interacts with his patients on an equal basis. To the extent, however, that he practices faith healing without the knowledge or consent of his patient, he is domineering (█▲). Similarly, those relationships in which he emphasized the "specialness" of his gifts can be symbolized as █▲.

CHAPTER 6

DEV SINGH, SIKHISM

Perfectionist. (Type III)

Scholarly information is not yet available on the new sect of Sikhism of which Dev Singh is a member. This brief introduction is dependent on both popular and the sect's own literature.<sup>1</sup>

#### BACKGROUND

Dev Singh is a member of an organization called the Healthy-Holy Organization (3HO), whose head, Yogi Bhajan calls himself the "Supreme Religious and Administrative Authority of the Sikh Religion in the Western Hemisphere." In many ways, Bhajan functions administratively and spiritually like the Pope. Sikhism is a blend of Hinduism and Islam. Millions of Indians practice Sikhism. The kind of Sikhism preached by Bhajan, however, is widely divergent from that of his native India. Indeed, orthodox Sikhs have accused him of heresy. Bhajan preaches a synthesis of aspects of Sikhism, Kundalini yoga, vegetarianism and his own idiosyncratic philosophies and doctrines. In nine years since immigrating to the United States, he has created a burgeoning sect of several thousand people with 110 ashrams of various sizes in the United States, Canada, and overseas. 3HO members, mostly white middle class young adults, manage a variety of businesses for the benefit of the sect including shoe stores, health food stores and restaurants.

The multitude of healing techniques used by members of 3HO cannot be neatly summarized. Indeed, the most important technique-- that of a therapeutic milieu-- embodies the whole

of the 3HO life style. Membership in Bhajan's sect is membership in a spiritual family-- on a local level in an ashram, a spiritual commune, and nationally in the whole organization.

In this sense, the organization has served as a haven for many otherwise lost young middle class people. An ashram's therapeutic milieu is used also for the healing of non-sect members.

Aside from the multitude of teachings about the healing powers of certain herbs, diets, and ritual practices, Kundalini yoga is probably the most distinctive healing technique used by American Sikhs. Significantly more vigorous than the widespread Hatha yoga practiced in the United States, Kundalini yoga is not simply a ritual practice or preventive medicine. Numerous exercises specific for particular physical, emotional and/or spiritual illnesses are used. More generally, this type of yoga is meant to release and afford control of a powerful universal creative energy, Kundalini. Spiritual development through following the 3HO life style and mastering Kundalini yoga purportedly allows perfect health. 3HO also offers support and therapy for many lost or ill people who are not interested in adopting the entire life style of 3HO.

#### PERSONAL PROFILE

Dev Singh is a twenty-seven year old, recently married, Class I Sikh, who has been the leader of an ashram in New Erehwon

for three years.<sup>2</sup> He was born into a cosmopolitan, wealthy Jewish family in New York. His father is a prominent businessman and is a trustee of a well-known academic hospital. Dev Singh was raised by a nurse. His father was in the hospital for practically all of the first ten years of Dev Singh's life. To this day, Dev Singh is unclear as to the exact nature of his father's problem. At any rate, he says his parents "packed me off to a psychiatrist to see how all of this was affecting me." He began psychotherapy in second grade. Except for a two year hiatus during junior high school, he continued in therapy until his graduation from high school. Dev Singh's description of this period of his life is not explicit except to say the he "felt lost."

Decision to Begin Unorthodox Healing

After two and a half years of college, the experience of walking into his dormitory bathroom and surprising a couple of black kids injecting themselves with heroin, prompted his dropping out of college. This incident marked the beginning

of a search for a spiritual discipline that he had felt the need for since an early age. The story of this search is the story of his personal healing and involvement in the healing of others.

Dev Singh lived first in a Christian commune and then in a Satchidananda ashram (an Eastern sect separate from 3HO) before he entered the Sikh sect 5 years ago. No particular revelation occurred. He initially was simply trying another spiritual discipline, but Dev Singh found a home in 3HO. What is more, his teacher, Yogi Bhajan, told him "... if I (Dev Singh) leave this family, I will have a very agonizing death. I really believe that I'd have been a total physical wreck without the family." Dev Singh's advancement in the hierarchical structure of 3HO to the status of teacher has been a function of discipleship more than formal training. His promotion within the organization was based on his superior's personal recommendations to governing councils. Spiritual advancement is theoretically the foundation for these recommendations.

Today, besides serving as the leader of an ashram of thirteen men, women and children, he is also the proprietor of a health food store managed by the ashramites. His role as a healer is inseparable from his position as teacher in his ashram, and more broadly, from his membership in a spiritual family. He did not decide to be a healer, rather

this function has evolved from his involvement with 3HO. Dev Singh does, however, have a particularly intense interest in healing which was sparked by his own ill health-- both emotional and physical. To Dev Singh, his ailments, including recurrent eczema and chronic neck pain, are spiritual trials which cannot be resolved through orthodox methods. In search of a resolution, he has, he feels, accumulated not only techniques, but also spiritual qualities which have facilitated his growth as a healer.

Furthermore, 3HO itself has a special interest in healing. Its leader has written about the use of herbs, diet, yoga and spiritual discipline in healing. Further, there is a regularly published journal from the Kundalini Research Institute which is devoted to the investigations of the use of Kundalini yoga and related methods in healing.<sup>1</sup>

Today, Dev Singh is a bearded, soft-spoken, warm, articulate, spiritual man, who is candid about his feelings and personal life. Always dressed in white with a turban covering his uncut hair, he is an easily recognizable person in New Erehwon. His remarkable ability to laugh at himself and the practices of 3HO make him easy and enjoyable to talk with. I was surprised then by his descriptions of what must have been a difficult childhood.

According to Dev Singh, his relationship with his parents is strained. Their few interactions are largely unpleasant

reminders of how differently parents and son live their lives.

#### Attitudes Toward and Knowledge of Scientific Medicine

Dev Singh is not dogmatically or flamboyantly anti-orthodox medicine, but he is profoundly skeptical of the value of its practices. For strictly mechanical problems, e.g., acute trauma, he endorses the use of medicine and applauds the progress made in orthodox treatments. More emphatically, however, he believes that "Medicine has neatly camouflaged what health is really about because it has opted for the simplistic mechanical approach that has discouraged people from using more natural slow means." He continues in the same vein, "Take the whole thing with Karen Quinlan. Medicine developed life supporting machines, but not an ethic to go with it."

Dev Singh reads extensively about unorthodox healing practices. His knowledge of scientific medicine, however, is surprisingly minimal considering his level of education. He could not name even one of the early warning signs of cancer. All he knew about diabetes was that a diabetic has a "funny reaction" when s/he eats food. And a heart attack was a "heart murmur or pause."

#### Religious Affiliations, Beliefs, and Practices

Broadly speaking, Dev Singh's spiritual beliefs are congruent with the major tenets of traditional Sikhism (Basham 1959). He believes in a poorly defined omnipresent spiritual force.

It is his devotion to his teacher, Yogi Bhajan, that provides spiritual direction to his daily life.

Dev Singh took this name on baptism in 3HO. Since then, he has entirely adopted the 3HO lifestyle, which is in some ways similar to traditional Sikhism. He lives in a sparsely furnished ashram with his wife and members of his spiritual family. Virtually all of his material possessions were given up on initiation to the sect. Every day he rises at 3:30 a.m. for three hours of Sadhna-- ritual spiritual practices including Kundalini yoga, reading from scriptures, and meditation. Other aspects of his life in 3HO include a strict vegetarian diet, an arranged marriage to a virtual stranger, and service to the larger community of wo/mankind. As part of this service, a free vegetarian meal is prepared weekly by the ashram for the New Erewhon community.

#### Illness Beliefs

Dev Singh believes that disease is a state of "un-ease", that is, "a lack of harmony among the different components of being (body, mind, and spirit). Whether a person perceives him/herself as sick "is a question of whether they want to respond to the

positive or negative in them-- whether they respond to their plans, their hopes and joys or to their fears and sickness. It also has to do with their identification. If you feel yourself to be a soul-- that part of you can't be sick, like when I wasn't well, I said my neck hurts, but I never felt that I was sick.

He goes further in defining why some people seem to get sick while others do not. In part he says, this is due to the "simple stuff of working too hard, not getting enough exercise, eating bad food, etc." More importantly, he believes that peoples' susceptibility to disease "has to do with their aura (roughly energy field). The more powerful the aura, the less negativity can enter." Ultimately, Dev Singh believes that illness is a manifestation of a person's karma. In this way, it is a kind of spiritual trial whose resolution has far reaching significance for a person's future.

#### Conception of Health

A physical state of well-being is only one part, a minor part, of Dev Singh's conception of health. "Someone who is in a wheel chair or who is blind could be healthy. It's more a feeling of well-being. It's an integration of inside and outside, of the conscious and subconscious." He believes that everyone has "the birthright to be healthy, happy and holy." A state of perfect health is possible and is defined by "an identification with the soul within and without you."

#### Healing Philosophy

Dev Singh de-emphasizes the role of healer in the healing process. Ultimately, because illness has a spiritual genesis, healing must occur in a spiritual plane. Only by "recognizing one's soul can disease be ended." The healer at best can only

facilitate this process (O $\Delta$ ). A spiritual family, rather than an individual person, is best suited to provide the support and discipline needed for this kind of healing. Dev Singh says that "the most healing thing is chanting God's name and keeping the company of the holy (i.e. living in an ashram). Secondly, the Sikh life style and Kundalini yoga are in a general sense healing.

Although a spiritual group consciousness is at the foundation of all healing, Dev Singh does recognize the usefulness of spiritual teachers as healers. The ideal healer, exemplified by Yogi Bhajan

has through his own diligence and God's grace become totally liberated. He's fearless, with total compassion and total rigorousness at the same time for not yielding to anyone's ego. He teaches people how to live for each other. He teaches them that they have to do it (attain healing and spiritual growth) themselves.

Dev Singh finds a place for individual healers on another plane too. He distinguishes two levels of healing: "The first is getting your (spiritual) scene together. The second is the technical scene, "e.g., physical manifestations of illness. The first level of healing requires the active participation of the patient with perhaps the assistance of a spiritual group or teacher. On the second level, the patient plays a more passive role. S/he is dependent on the technical skills of an expertly trained healer. The healer, too, takes a more active role in this case. Dev Singh feels that he can play both roles. More frequently, in his healing of non-Sikh patients, he is called

on to exercise the role of a technical adviser, for example as a yoga teacher or herbalist. Whatever technique he might employ, it is always a "natural" (i.e. non-medical and non-surgical) method which assumes the healing presence of God and the discipline of the patient. Even as an individual, more technically minded healer, healing to Dev Singh, "is based on the power of the aura, purity of the aura and the ability to project it." (O□Δ) In the final analysis, he feels that "a particular technique is only an excuse for touching another person with my aura."

#### Healer-Patient Relationship: Expectations and Satisfactions

Both 3HO members and non-members are treated. Dev Singh feels that potential 3HO members seek his spiritual family for far more than simple physical problems. On one level, he believes that people are drawn to the healing auras of the Sikhs, but that "in a larger sense, what they're (the patients) seeking is to make their life whole and to fulfill their destiny in all of their potential." Dev Singh finds that people with no intention to join the ashram are nevertheless drawn to a particular aspect of the 3HO lifestyle, e.g., diet, yoga, for healing purposes.

Dev Singh usually looks beyond the present complaint of a person. "People come with a complaint, but I treat something broader." He finds that although "People usually know what's

the matter with them..., they don't want to voice it publicly." For example, "Someone might come because they want to lose weight, but I see the problem as one that they have anxiety." For another patient, who presented with leukemia, Dev Singh focussed on the patient's anxiety, sleeplessness, and family difficulties. Indeed, during our interview, Dev Singh had forgotten that this man had leukemia. In my talk with the patient (number IIIC), he corroborated that Dev Singh was accurate in terms of what was actually most bothersome to the patient at the time of seeking care.

Dev Singh believes that the teacher's relationship with a patient should not be one of friendship. "Some distance is necessary. Our life style is pretty reserved." He does not think that he has much conflict with non-BHO patients. He does not expect to be their main source of care. Nor, does he expect them to share his spiritual beliefs. He seems to insulate himself from possible frustrations and disappointments with the rationale that "We put our faith in God, not in people. Whatever they do is karma." Within his spiritual family, however, the rigid authoritarian social hierarchy characteristic of BHO is the basis of some conflict. In this setting, Dev Singh expects obedience from the ashramites. In any case, if a patient really "... wants to be healed, he's got to believe in the healer. He must have the discipline and courage and will to go beyond his ego and his fears."

To Dev Singh, the most satisfying aspect of healing is that he serves as a healthy role model. "We're practicing what we preach. There are so many doctors you go to that are unhealthy. How are you to believe in what they're saying." The least pleasing aspect of his relationship with patients is that "It's a total power trip."

This last point contributes to the apparent paradox in Dev Singh's philosophy of healing and his perceived relationship with his patients. Within his spiritual family, he is admittedly and purposively authoritarian. In this case, his social relationship with patients must be distinguished from the manner in which he believes the healing process occurs (■▲) An analogous relationship occurs with the Zen master and his novice. There is little question that this relationship is authoritarian. Nevertheless, the master would be the first to deny that he could force the enlightenment of his student. Spiritual advancement can only be the student's achievement. A counter example is the surgeon with an authoritarian professional relationship with patients who believes that he indeed is primarily responsible for their well-being. Dev Singh expects to be, and in my observation, is authoritarian in his healing of ashramites. With others, however, he intends, and in fact engages in more of an advisory role on an equal social footing as his patients (■▲). His unsettling idea that he is more powerful than the patient in this setting does not check with

my perceptions. Other members of the sect tended more to place themselves in a servant role to all of their patients (▲).

#### PRACTICE PROFILE

##### The Day, The Patients

Dev Singh has the least active healing practice of all healers whose case histories are presented. He treats approximately 1-2 people per week for physical complaints. In fact, this finding is grossly misleading. It is an artifact of the research design. The vast majority of Dev Singh's patients see him for preventive or strictly psychological or spiritual problems. This type of patient visit was excluded from investigation (cf. p. 33). Further, if the ashramites were taken as a group, as indeed they would prefer to be considered, they treat many more physically sick people. These considerations are best appreciated by a brief account of the varied activities of the group which they consider as preventive or healing practices.

Three days a week, Kundalini yoga classes are taught by one of the group members. These classes usually have six students apiece. Two group members offer shiatsu massage and usually each have two to three "patients" apiece per day. The health food store daily offers nutritional and herbal advice to an untold number of people with physical problems as well as interests in maintaining their health. The store

also offers a program in weight control featuring counselling and a liquid protein diet. Finally, the ashram occasionally offers public workshops on such topics as the use of yoga for weight control or more generally yoga and healing.

Dev Singh's day, then, is mostly occupied by his spiritual practice, running the health food store and teaching yoga. His treatment of non-Sikh patients occurs either in the store or in the ashram. Except in the case of counselling or group healing ceremonies, it rarely takes more than a few minutes. Sick Ashramites' treatments are integrated into the entire day.

Dev Singh was the primary healer for 6 patients during the survey month (3 were intensively interviewed-- patients III B,D, and E, Chapter II). They ranged in age from 23 to the late 70's. All were white and 4 were from social classes I, II or III. Five of six patients were male. Two of the six were ashramites. Dev Singh had seen 4 of the 6 for the same problem before. They had all been referred by satisfied patients. Only 2 were charged-- \$2.00 apiece. The problems presented included low back pain, headaches, fatigue, obesity, infected fingers, and chronic abdominal pain. Treatment recommendations included dietary, herbal and yogic prescriptions and spiritual counselling.

#### Organization of Practice

##### The Place

Dev Singh practices in either the basement of his health

food store or his ashram. The health food store is attractively designed, meticulously clean and well stocked with natural foods, herbs, and a library of healing books. Outside the store is a sign advertising Yoga classes, massage, and dietary counselling. The basement is totally distinct from the main store, and is essentially barren except for wall to wall pile carpeting.

The ashram is a large old house in a well to do residential neighborhood. The house is mostly remarkable for its sparse furnishings and religious symbols on the walls. Yoga is practiced in a large common room and there is one room reserved for consultations.

#### Interaction with Other Healers

Dev Singh's practice is shared with seven ashramites who either assist in teaching Yoga, dispensing nutritional advice, giving massages, or group healing ceremonies. As a member of 3HO, Dev Singh is expected to report regularly to a regional Sikh governing council and ultimately to Yogi Bhajan. They oversee his activities in a general way, but do not directly supervise his healing functions. Most regularly, there is association with a nearby 3HO ashram, but Dev Singh also participates in ceremonial activities and spiritual pilgrimages with members of ashrams from across the nation.

Dev Singh refers patients to Type V and VII healers, especially homeopaths and chiropractors-- rarely to a physician

if an acute threatening illness has occurred. He also refers patients to more advanced Sikh healers including Yogi Bhajan himself. Some Type V and VII healers including an unorthodox physician refer patients to the ashram. Dev Singh's impression, however, is that most of his patients outside of his ashram are referred by other patients or learn of his activities through advertising or the free vegetarian meals.

#### Interaction With the Community

The 3HO ashram and its activities are easily identifiable in the community. Their main interactions are through free meals, the store, and the yoga classes. Dev Singh perceives no friction with organized medicine. On the other hand, 3HO has recently received considerable bad press (Time September 5, 1977). Its leader has been accused of womanizing and luxurious living as well as heresy. There have been parents who have kidnapped children to have them deprogrammed in a manner similar to what has occurred with Reverend Moon's Unification Church.

#### OBSERVATIONS OF PRACTICE

Dev Singh uses an eclectic collection of healing techniques. Very much up to date with the unorthodox healing literature, he is apt to use virtually any "natural" healing therapy. The mainstays of his armamentarium, however, include the prescription of particular yogic exercises, diet, herbs or more specifically spiritual therapies. The latter might include meditations,

chanting, or group healing ceremonies.

In Dev Singh's first interaction with a patient, he attempts to arrive at an analysis of a person's problem by taking a history, testing muscle tone and strength (kinesiology), iridology (cf. Chapter 9) and most importantly, by an intuitive feeling. This last factor of the analysis is based on his intuitive sense of the strength of a person's aura and of his/her nervous system as manifested by his/her movements in a yoga class. Most frequently, this phase of treatment is brief (a few minutes) and informal.

Most treatments of non-BHO patients are fairly straightforward business-like interactions that last a few minutes. Yogic exercises are actually demonstrated. More striking, are the group healing ceremonies which occur in the context of an illness of a member of the ashram or of a yoga class. The patient is asked to lie supine in the center of a circle of fellow patient/healers who sit cross-legged around him/her. With their arms outstretched at 120 degrees from their trunk, supposedly a healing angle, they intone a special healing chant for as long as one hour. If nothing else, patients appreciate a tremendous sense of relaxation and social support.

Treatment of ashramites involves: (1) the patient's release from any social responsibilities, (2) the patient's assumption of a dependent role, (3) spiritual counselling and inquiry into the spiritual significance of the illness, (4) a

prescribed dietary, yogic, and spiritual regimen. In some cases, non-ashramites are invited to move into the ashram for a limited period of time for intensive therapy. In this case, they receive essentially the same treatment as ashramites.

Beyond simple physical changes, Dev Singh judges the efficacy of his treatments by looking for changes in life style, behavior patterns and most importantly, auras. Occasionally, he observes side effects of intense spiritual and yogic therapy. In these cases, people apparently regress emotionally as "they work through some things that were repressed."

#### IMPRESSIONS OF PRACTICE

Dev Singh is a young man from a Jewish family of profoundly different values. After years of emotional turmoil, he has found a modicum of peace within the 3HO family. He, like Joe Carbonella, is a man whose personal gift for healing has emerged from his own search for health. Dev Singh's practice has been shown to center on his belief in personal auras whose integrity are a function of people's closeness to God. In the event that a person's aura is weak enough to allow a deviation from perfect health, a spiritual healer can assist in the restoration of health. To heal, Dev Singh believes that he must be healthier (i.e. closer to God) than his patient. Perhaps it is this belief that prompts him to take a more active role in his relationship with patients than might be initially suspected from his healing philosophy.

## CHAPTER 7

MR. LENNY GRASSO, PSYCHIC HEALER  
Spiritual (Type IV)

Lenny Grasso is an example of the Spiritual philosophy of healing. His case study re-emphasizes some of the themes raised in the investigation of the previous healers, and as well, points to further areas of relevance to a study of unorthodox illness behavior.

#### BACKGROUND OF TECHNIQUE

LeShan (1974) provides an orienting paradigm relevant to this case study. Based on the experience of the healer, LeShan divides psychic healing into two main classes, Type 1 and Type 2. In Type 1 healing, the healer enters an altered state of consciousness in which s/he perceives him/herself and the patient as one entity. The process involves entering a meditative state and psychically merging with the patient in an experience of "all is one". The patient need not be aware of, or even present during, the healing. Although the healing may not have any kind of religious connotations, Type 1 healing is theoretically predicated on agapé. Type 2 healing does not involve a mystical experience. In this case, the healer places his/her hands on either side of the patients' pathological area and concentrates on the perception of a flow of "energy" passing from healer to patient. Usually, this "energy" is perceived by healer and patient alike as warmth or a draft. The healer using Type 2 healing literally tries to heal. Although theoretically more efficacious when s/he cares for the patient, the profound empathy of Type 1 healing is not necessary.

Psychic healing, particularly Type 2 healing (laying on of hands) is used by healers of virtually all philosophical categories. In fact, Type 2 healing has been studied with animal models (Grad 1961, 1965, 1970) and incorporated into the training of some orthodox health professionals.<sup>1</sup>

#### PERSONAL PROFILE

Mr. Grasso is a forty year old, social class III, married,

Italian man with two young children.<sup>2</sup> Raised with three sisters in a Roman Catholic Italian family, his social background has been parochial. After a high school education, he began working at semi-skilled jobs. For the past several years he has managed his own painting and paper hanging business with the assistance of a few employees. Except for military service which took him to Europe, he has lived in the Greater Erehwon area all of his life.

#### Decision to Begin Unorthodox Healing

Mr. Grasso traces his involvement in psychic healing to about three years ago. At the time, he had been taking karate lessons for a year and a half. He remembers himself as being very aggressive and egotistical. Karate literally reflected the kind of control he wanted over people. One night he went to a hypnosis class that his wife was taking. To his considerable surprise, he had a mystical experience.

On that first night, the sensitivity of my hearing greatly increased. The coffee pot sounded like a railroad train. I felt like I was vaulting through my crown Chakra. Originally, I knew nothing of this.

He continued with hypnosis for five months before taking classes at the Psychic Healing and Research Institute in Erehwon. He recalls as extraordinary, the rapidity of his psychic development, "What has happened to me in three years hasn't happened to others in two hundred years." He accounts for this meteoric advancement by his belief, allegedly confirmed by other psychics, that he has already lived several spiritually advanced lives.

Mr. Grasso first began healing two years ago.

A teacher in my (psychic healing) class asked me to stay after class and help with a healing. A girl, barely able to walk, shuffled into the room. I healed her. She walked right out of that room. That convinced me that I had to do more.

Subsequently, he participated regularly in a healing group

and began teaching classes in healing at the Psychic Institute. He sees his advancement as a healer to have been a function of his spiritual growth in this life and his experience in past lives, rather than due to any particular training. "Most of my growth comes from knowing me-- knowing the false within me." Mr. Grasso speaks frequently of factors providing the incentive for this growth. Especially important has been the effect on his ego of realizing his psychic powers. Mr. Grasso breaks his growth in this area into two phases.

The higher the level of healing you deal with, the less conspicuous the healing is. On the first level, you deal with the initiative of yourself. It's you who are healing.... Now, you have the capability of swaying people. Like Hitler, you are stuck on the will aspect of Kundalini (a spiritual force).

He said, initially, his incentive to realize his powers was first level.

The thing that made me grow faster than anything was that they (the staff of the Psychic Institute) were scared of me. They would always say I frightened them. They couldn't handle me coming up the ladder so fast behind them. They said everything I do is ego. They tried to crush my ego. That would've been terrible.

In fact, Mr. Grasso succeeded in pushing out the original staff of the Psychic Institute so that two years ago he became its director. He soon recognized, however, that this behavior was no more than psychic karate.

I can actually control someone if I want to. My thoughts can manifest into matter. Everyone can do this, but I've got more energy than others. I've got to control my thoughts on this. Keep it on a spiritual level so I don't get egotistical.

Mr. Grasso believes that most psychic healers are fixed at this level of development.

Ninety-nine per cent of psychic people today are quacks. They are people dealing on a physical level trying to sway people. Anybody who tries to change you is not dealing with a higher source of consciousness.

The turning point for him was a particular experience with a patient.

The thing that made me understand healing more than anything else was healing a child of an earache. I had been projecting energy for hours and there had been no change until I came out of the room and they (his spiritual sources) told me that the problem was that God wasn't in my energy. I went back into that room caring and the child got better instantly.

According to Mr. Grasso, he was at this point able to rise above egotistical concerns and enter phase two of his healing career. His healing took on a more highly spiritual nature after a mystical experience in which he suddenly felt "an overwhelming love for all mankind." As a function of this "enlightenment", he began to "realize why the ailment is there. What problem has caused the physical deficiencies." As will be seen, this transition between phases of his career has not been either smooth or complete.

On one hand, Mr. Grasso will deny any credit for his healing powers. He does not feel they are skills he has acquired. Mr. Grasso purports to have spiritual "sources" which communicate to, and through him, information and powers that are beyond his personal skills. There is no question that Mr. Grasso feels that he has a special gift. Although some of his powers he attributes to his healing practices in past lives or to his link with spiritual sources ("Three physicians are with me at all times."), he often refers to himself as a kind of healer incarnate. As is evident in the following quotations, implicitly and sometimes explicitly, he compares himself to Jesus Christ. Personally, he feels omnipotent, "I can't be hurt. I have so much energy nothing can bother me," and yet paranoid, "Occult groups send women down to blackmail me. They attack me because I have the ability to annihilate them with one thought."<sup>3</sup>

I asked the source "Why am I a painter?"  
"Because we wanted to show that an ordinary man can do it."

"Why am I not better educated?"

"Because we want to show that education has nothing to do with it."

I can imagine what Christ went through. I put myself in His place many times. No one could understand the man.

No one listens to what I say. I can't let that bother me. If I can't rise above that injustice, I can't rise above any.

Sometimes it gets very lonely. I can see Him walking on that desert.

I engage in the healing of humanity, just by being here. As part of the earth, my growth helps the growth of the earth.

I go one step beyond Christ. He was here to bring the Essence to the earth. I'm here to show people that they can be the Essence.

Mr. Grasso is a well-dressed, loquacious, attractive man appearing younger than his stated age. His presence, undeniably powerful, has much more of an egotistical than a spiritual quality. He is intimidating. I often had the feeling that if he couldn't accomplish what he set out to do psychically, he certainly could physically. His language is laced with an amalgam of conventional and personal religious terminology. In many ways, his behavior was similar to that of a well-compensated paranoid schizophrenic. He had a personalized language, frank visual and auditory hallucinations, ideas of reference, delusions of grandeur, paranoid ideation, and a remarkably unconventional sense of reality. The use of these labels, however, may say more about my fears and preconceptions than about his personality. Glib characterization of psychics as schizophrenics may only block productive inquiry into their claims and their practices. LeShan (1976) quotes Otto Liebman on this point.

Disbelief in miracles is conceptually equivalent, or synonomous with 'believing firmly in the absolute

lawfulness of all events without exceptions'. When we are certain that a phenomenon such as firewalking does not happen, we are really saying 'My basic knowledge of how the universe works is so complete and so accurate that the cosmos holds no more surprises for me. I know all the real truths and the details will all fit them.'

Therefore psychiatric labelling may be misleading. The key point is not whether Mr. Grasso's behavior is psychopathologic, but that he is struggling with ways of coming to grips with new and powerful psychic phenomena. In fact, he epitomizes a struggle common to many healers who are aware of a healing power that goes beyond their technical skills (cf. Chapters 5,7 and 8).

#### Attitudes Toward and Knowledge of Scientific Medicine

In general, Mr. Grasso is quite positive in his evaluation of medicine. Neither he nor his immediate family has had serious illness. Routine medical care has in his estimation always been satisfactory. His main gripe with physicians is "how rigid minded they are. Plus, their first priority is their ego, rather than patients. They think they are almighty gods. When someone else heals, they can't take it." Note the similarity to my discussion of his attitude toward healing and patients (pp. 148-9).

The nature of my relationship with Mr. Grasso did not allow direct assessment of his medical knowledge. In the context of our discussions, his knowledge seemed commonplace.

#### Religious Affiliations, Beliefs, and Practices

Mr. Grasso was born into the Catholic Church. Although he is bringing up his family within this tradition, he thinks that "organized religion is a mockery." Only rarely does he go to church. Instead, Mr. Grasso has formulated an eclectic melange of personal spiritual beliefs and practices that are founded on the symbolism, theology and terminology of

Catholicism, but branch into mystical, occult and Eastern philosophies. Such concepts as reincarnation, karma, spiritual growth, Chakras, and personal spirits are mixed freely with more traditional Christian ideas. His conception of God is that He was responsible for creating a set of cosmic laws that are immutable and now demand even His obedience. As the Essence of the universe, He provides meaning and is the well-spring of cosmic energy. He can only act on the physical plane through people who know Him in the most profound sense.

Prayer is not enough. God cannot heal you. He is so just that even He must follow His laws.....

God is so just that He can't help anyone. The only way is for someone on this dimension who comprehends the Essence and understands that sick persons affect others. Because I am part of this level (the physical level), I have the right to help.

Mr. Grasso's spiritual practices, as his beliefs, have become virtually inseparable from his healing activities.

#### Illness Beliefs

Mr. Grasso's theory of illness takes root in his belief that a person has seven chakras (ordered from the basest, the root, to the most etheric, the crown). Each chakra is associated with a particular gland, a color, and a set of social characteristics (cf. Chart 7A). These latter are what he calls "thought patterns." For example, honor, decency, and desire are associated with the solar plexus chakra. He sees each chakra as representing a level of consciousness. As a person grows spiritually, his/her thought patterns are more consistent with those of ever higher chakras.

Mr. Grasso believes that all illness is a function of "imbalances in thought patterns." In other words, a person who is ill is not living according to the cosmic laws. For example, a person who is not living decently may manifest an illness at the level of the solar plexus chakra. In this

## CHART 7A

GRASSO'S PERSON<sup>4</sup>

<u>CHAKRAS</u>	<u>GLAND</u>	<u>COLOR</u>
Crown	Pituitary	White
Third Eye	Pineal	Lavender
Throat	Thyroid	Blue
Heart	Thymus	Green
Solar Plexus	Pancreas	Yellow
Sacral	Gonads	Orange
Root	Adrenal	Red

case, the pancreas would be affected. As part of his diagnosis of a person's problem, Mr. Grasso claims to both see and feel a deficiency in the radiance and color of a person's aura (roughly-- an energy field) at a given level. Thus for a person with a pancreatic problem, he would feel an "energy draft" at the solar plexus chakra. Yellow would be less intense at the same level.

One further dimension to Mr. Grasso's illness model is that a person is composed of physical, mental, and etheric (spiritual) qualities. Physical qualities correspond to the glands. Mental qualities are manifest as thought patterns. And, etheric qualities are represented by the chakras. Illness may affect any or all of these components of a person.

Mr. Grasso believes that many of the problems that doctors cannot diagnose, but that he can, are in fact problems on the etheric level. Too, he observes that physical symptoms do not always have an organic basis.

Illness is sometimes an illusion, but if people have this illusion, they will be ill. I tell them that they are deteriorating themselves with a thought pattern and that I haven't found a deficiency in that area (chakra), but if you continue to have negative thought patterns you will cause a real illness.

In the final analysis, he believes that "one half of all problems (discovered by doctors) will go away, unless they (the doctors) tell patients of the problem (and thereby reinforce negative thought patterns).

#### Conception of Health and Philosophy of Healing

To Mr. Grasso, health is a balance in thought patterns. It is "using the total essence of you and not totally for you." It reflects the "relationship of you to your body and to humanity." Healing is a process of balancing thought patterns and re-ordering one's relationship to oneself and to humanity in accordance with the cosmic laws. Whatever

healing technique Mr. Grasso may use (pp. 1447-7), he believes, that it is not himself that has done the healing. On one hand, there is the higher power, "What you have to know when you're doing a healing is that what has done the healing is the Essence that you have contacted." On the other hand, there is the patient, "It is you (the patient) who is healing, but you must know who you are (i.e. know your spiritual essence). If you just sat there and said God, 'I'm your vessel. Heal!', there is no spiritual growth." Mr. Grasso does not force change (balancing). He is the medium  $O \square \Delta$ .

If I can make them (his patients) deal with the essence of the problem that they are working with now, then I have done my job. I must stir up their energy to work on the problem themselves. If I get someone in motion, then I've done the greatest injustice in the world.

In this vein, Mr. Grasso sees teaching as a form of healing. In his psychic classes he helps people learn to balance themselves before they have physical manifestations of illness. "The highest dimension of healing is preventing the illness."

The ideal healer is characterized by

- 1) love for humanity
- 2) egotism in the sense that you want people to look up to you (note the inconsistency, cf. above).
- 3) dedication to self, solving problems within the self in order to comprehend the essence of problems in someone else. Show me a psychic healer who is sick and they are doing nothing.

On this last point, Mr. Grasso expands, "One can actually, if you're not strong enough, get the patient's disease. But I'm not afraid of that. If I get to the point that while I'm doing a healing I get the disease, then I deserve it."

#### Healer-Patient Relationship: Expectations and Satisfactions

Mr. Grasso rarely expects to be the main source of care for a patient. In fact, if a person has not already been to a doctor, Mr. Grasso recommends that the person seek orthodox

care concomittantly with psychic treatment. Mr. Grasso finds that most people are referred to him by other patients or through his radio advertisement for psychic development classes. He believes that family support is a critical factor in a person's decision to seek his care.

He never turns a patient away. Often he perceives that someone is ill who has not requested help. In these cases, he sometimes, but not always offers assistance. He points out that "sometimes it is negative to offer because you frighten them so much that you cause destructive thought patterns." In any case, most of his patients initially are afraid of his power to control them. Because of this fear, he recognizes an even greater importance in assuring his patients that he cares for them. Yet, he sees a further risk in this manner of projecting himself in that many women are sexually attracted to him. This type of attraction he feels is counter-productive to spiritual growth and healing.

Usually he finds that patients initial visits are motivated by a single desire, "to eliminate that which is bothering them." To his frustration, "so many of them go back home without changing their thoughts patterns, and then their physical problems come back." Healing is not his job alone. His patients have the major responsibility.

I can perform an instantaneous healing, but the basic problem is still there. They (the patients) are still dispersing energy, which is causing the physical problem. I've seen so many cases walk out of here healed and then they're back in a few months with the same problem. Why? They haven't changed their thought patterns.

Another frustration is that he finds that, from his perspective, some people improve physically and do not realize it (cf. patient number IVC). He claims, in fact, that he has never seen one case in which there was not at least a transient improvement. Although he is admittedly frustrated by patients who do not

take his advice, all that he asks of the good patient is that s/he be receptive. Mr. Grasso does not see his role as one of demanding compliance. He offers information and/or access to cosmic energy. The patient can do with it what s/he wants.

#### PRACTICE PROFILE

##### The Day, The Patients

Mr. Grasso's practice is confined to the hours and days that he is free from the responsibilities of his principal occupation. Three nights a week, he meets with patients and students for psychic readings, healings, and classes. On other days, he purportedly sees patients at their homes, or does absent healing from his own home (cf. p.81). Mr. Grasso was not willing to use the patient survey forms to keep an accurate record of his patient contacts during the study period. His secretary did her best to record these interactions, but she could not confirm Mr. Grasso's healing activities outside of the Psychic Institute. Accordingly, the descriptive information about his patients is sketchy.

Mr. Grasso states that he normally sees about 10 patients per week outside of the Institute. The majority of these patients he has seen before. He receives about 5 phone calls a day from patients he has seen before. (During one two hour interview at his home I counted 3 calls.)

Routinely, while at the Institute, Mr. Grasso sees each night 1 person for a psychic reading and 2-5 patients for healings. In 8 non-randomly sampled nights during a month, he saw 7 different patients for a total of 25 times. All of his patients, then, were seen multiple times. They ranged in age from 16 to 73. One (1) of the 7 patients was black. All others were white. Six (6) of the patients were in classes I, II, or III. Three (3) of the patients were male. Three (3) of the patients were referred by other satisfied patients. The

other 3 had first been attracted to the Institute for psychic development courses. None were changed for the healings. The problems presented included asthma, cataracts, scoliosis, parkinson's disease, Granulomatous colitis, Sjogren's syndrome, and concern for the meaning of various psychic events. Treatments included psychic counselling (in deep trance), color therapy, nutritional recommendations, and Type 1 and 2 healing (cf. p. 131). All of these patients obtained symptomatic relief from the treatments in my presence.

#### Organization of Practice

##### The Place

Mr. Grasso's consultation office is located at the Psychic Healing and Research Institute, of which he is the director. The Institute was founded approximately a decade ago. Since then, research has never truly been one of its activities. Rather, its focus has been on psychic healing and classes in psychic development. Currently, 3-5 classes of 2 hours apiece are offered each week. Enrollment per class is in the vicinity of 20 people. A course lasts from six to eight weeks. Depending on the time of year, 3-5 healing groups composed of 5-10 graduates of the healing courses meet at the Institute during the week. Mr. Grasso directs the activities of the Institute with another man (a Ph.D. in biochemistry) and a woman who functions as a secretary.

The institute consists of five rooms in a business building. Classes and Mr. Grasso's private consultations are held in a large room filled with about 25 metal folding chairs, and a desk. On a blackboard is an outline of Grasso's model of the person (cf. chart 7A). Posted on a corner of a wall is "What you are is God's gift to you      What you make of yourself is your gift to God."

Besides 2 antechambers to the large classroom, there are

2 less frequented places. One is a smaller room where Mr. Grasso's Ph.D. assistant works on electronic gadgetry to measure auras. The other is a group healing room in the basement. It is remarkable for its circle of ten folding metal chairs around a low circular table. A small basket overflowing with handwritten names of people asking for healing sits next to a burning candle on the table during healing sessions.

Financially, the Institute's activities are supported by donations, a \$5 charge per class, and the \$15 charge per psychic reading. On the principle that healing is an act of love, Mr. Grasso never charges for his therapeutic ministrations.

#### Interaction with Other Healers

At this time Mr. Grasso desires, but has no professional relationship with medical doctors. Occasionally, other psychics refer patients to him. Mr. Grasso is aware of the two other large psychic healing centers in Greater Erehwon (cf. p.70 ), but he chooses not to interact with them because "they are dealing on a physical plane."

The activities of the Psychic Institute are advertised widely in local newspapers and radio stations. So far, they apparently have not incurred the wrath of medical authorities.

#### Observations of Practice

Mr. Grasso's healing practice involves both diagnosis and treatment. His practice consists of three categories of psychic techniques, deep trance, Type 1 healing, and Type 2 healing (p.131). One or all of these techniques may be used in a given healing session.

Mr. Grasso uses the first technique for psychic diagnosis and/or therapeutic advice. Alone in a darkened candle lit room, healer and patient sit facing each other separated by a desk, while eerie mystical music plays in the background.

Mr. Grasso asks his patient to sit relaxed with uncrossed legs and closed eyes. After meditating for 3-5 minutes, Mr. Grasso assumes a deep trance. This trance is initiated and punctuated by a gentle counter-clockwise circling of the head. At this point, with eyes either opened or closed, Mr. Grasso begins, "We (the sources) are ready." Although monotonous, Mr. Grasso's speech is conversational in character during trance. Throughout a typical 45 minute session, spiritual sources may either provide him with information or speak through him directly to the patient. In general, the patient asks questions to which Mr. Grasso responds, but occasionally, he offers unsolicited information. He actively discourages specific questions, but in my presence has answered many.<sup>5</sup>

The content of the trance sessions are usually characterized by Mr. Grasso pointing out a person's negative thought patterns and commenting on his/her relationships with significant others. Occasionally, specific predictions, diagnostic impressions or therapeutic advice are offered. Therapeutic recommendations were related to thought patterns or color therapy. For example, a patient might be told to live with more compassion and given meditative exercises to accomplish this behavioral change. The psychic classes were also offered as one road to the spiritual growth necessary for changing thought patterns. Color therapy consisted of recommendations for modification of the patient's environment to include more items of the color associated with Mr. Grasso's perception of a deficient chakra. For example, a person with negative thought patterns related to the heart center would be told to wear green clothes and to eat green foods. The end of a session is marked by the spiritual sources proclaiming

"We are through at this time." Mr. Grasso comes immediately out of trance and the patient leaves without further significant interaction.

The second technique employed by Mr. Grasso corresponds to Leshan's Type 1 healing (p.131). The patient's presence is not required (absent healing). Mr. Grasso goes into a meditative state and with compassion seeks to merge with his patient and all of humanity. Actually, Mr. Grasso characterizes all of his healing as taking this form... "I no longer do one on one healing. We are so tied together, our energy fields so integrated, that I heal humanity."

The third technique used by Mr. Grasso in treating patients corresponds to Leshan's Type 2 healing (p.131). In this case, after giving a brief account of his/her problem, the patient is instructed to sit relaxed. Directly in front of the patient, Mr. Grasso meditates briefly. While mentally scanning the patient's body, Mr. Grasso claims that images of the patient's state of health spontaneously come to mind. Next, he takes his right hand and "combs" (feels) the patient's aura while at the same time visually inspecting it. He keeps his hand approximately 6 inches from the patient and concentrates on the location of the chakras. After having spent 2-3 minutes assessing the patient, he begins the healing by placing his hand approximately 6 inches from his perception of the affected body part. For anywhere from 1-15 minutes, Mr. Grasso will concentrate on "sending energy" to the affected area. He uses suggestions profusely while asking patients to corroborate his perceptions.

Mr. Grasso and his patients were generous in allowing me to view many healing sessions. Many of the claims that Mr. Grasso made about his psychic powers, especially the more dramatic ones, eg. telekinesis, he declined to demonstrate. He told me he had ~~evolved~~ beyond the stage of performing "tricks". Nonetheless, I observed several examples of unusual

phenomena which he did effect. One case was a man who purportedly was followed in a local academic hospital for Sjogren's syndrome. The man, a machinist, complained that his eyes felt like sandpaper. Without natural tear secretions, he depended on the routine instillation of artificial tears. Mr. Grasso, diagnosing his problem as a lack of passion, used both Type 1 and 2 healing, 2 times a week for 6 weeks. On a number of occasions during healing sessions, the man burst into tears, crying in loud sobs. Between sessions the man reported a gradual improvement. Of note was that this patient, referred by a family member who had allegedly been healed by Mr. Grasso had complete faith in him. I could sense him straining to cry. One other example involved a Parkinsonian patient with marked rigidity and bradykinesia (patient number IVC). Using Type 2 healing, Mr. Grasso instantaneously relieved these symptoms. Mr. Grasso's psychic readings were similarly impressive. Although patients were usually unknown to him, he was able to make many specific interpretations about a person's life. Nearly always these comments not only were corroborated by the patient, but also evinced considerable psychological insight.

#### Relationship with Patients

Many of Mr. Grasso's patients behaved as though they were intimidated, even frightened by him (O). Indeed, he acted as though he had tremendous power. He occasionally alluded that if he wanted, he could move matter by his will alone or read and control people's minds. In fact, he was extraordinarily capable of captivating and manipulating an audience. His language was frequently patronizing-- calling men, "my son." Too, his special vocabulary often seemed to be used more for the purpose of mystifying than explaining. In contrast, verbally he usually emphasized to patients that they must take responsibility for their own healing by changing

thought patterns. He often spoke of the importance of compassion and humility. In classes, healing groups and individual healing sessions, Mr. Grasso commanded a tremendous faith from his patients and students alike.

#### IMPRESSIONS OF PRACTICE

Mr. Grasso presents a vivid example of the development and practice of a Spiritual healer. Of particular interest is the role of power in this man's initial involvement in healing and in his current practice. Mr. Grasso readily acknowledges that power was the incentive for his first involvement with psychic healing, as well as his fascination with karate. He feels, however, that through his involvement with healing, he has grown spiritually beyond the point where he needs to demonstrate his power. He can be content with knowing that he is powerful without proving it. Indeed, he feels that such demonstrations are destructive. Instead, he hopes to help people realize their own power. My observations, however, suggest that most people feel powerless before him. This response of his students and patients creates tremendous conflict for him. On one hand, he appears to hunger for ego inflating feedback, but on the other hand, he recognizes the negative ramifications of such an attitude for his personal growth and healing practice. Again, as with Joe Carbonella, I am struck by the similarity between a gifted healer, Lenny Grasso, and the gospel accounts of Jesus Christ. The similarity is particularly striking with Mr. Grasso because he vocalizes it. Instead of dismissing Mr. Grasso's behavior as psychotic, I believe it is worthwhile to consider what apparently is a virtually inseparable aspect of recognizing one's gift for healing.

Unbeknownst to him, Mr. Grasso's healing practice expresses some of his innermost conflicts. He believes that

healing is a process which primarily involves a higher power and a patient, with the healer acting as a channel for the healing energies (○ □ △). His personal struggles with power distorts this ideal. He closely identifies with the strength of the universal energies and in his work with patients tends to overpower them (■ ▲). Perhaps it is a desire to reduce this discrepancy between belief and practice which prompts Mr. Grasso to effusively (and religiously) proclaim his love for humanity.

## CHAPTER 8

DR. RICHARD LOWKAP, HOMEOPATH

Vitalist (Type V)

Richard Lowkap is a medical doctor who practices homeopathy with a Vitalistic healing philosophy.

#### BACKGROUND OF TECHNIQUE

Homeopathy is a system of medicine founded by Samuel Hahneman in 1790 in reaction to the aggressive medical practices of the time.<sup>1</sup> In the place of purges, powerful drugs, enemas and blood lettings he proposed exercise, good diet, fresh air, sanitation and personal hygiene to control disease. He also developed a new type of medical treatment called homeopathy. A major tenet of this treatment is that diseases or symptoms of disease are curable by drugs that produce similar pathological effects in the healthy body. In contrast to allopathy, the dominant medical orthodoxy of today, homeopathy proposes that not only the harmlessness, but also the potency of drugs is increased by using them in infinitesimal doses.

Homeopathy has been refractory to scientific investigation because it presupposes that every person is unique and that treatments must be individualized. Regardless of scientific justification homeopathy initially achieved considerable success in Europe, England and the United States. Since the turn of the century however the movement has declined. Nevertheless, homeopathy still is respectable in England and traditionally the Royal Family retains a homeopath as a family physician.

In Connecticut, since homeopaths are always medical doctors, they can practice legally. Even so, their practice is considered unorthodox with respect to contemporary American medical conventions. There is a Connecticut homeopathic medical examining board, but there has been no examination in 10 years for lack of candidates. The Connecticut Homeopathic Medical Society with only 12 members (all MD's), meets twice yearly to deliver papers. The International Hahneman's Societies and the American Institute of Homeopathy bespeak the widespread appeal of homeopathy, but currently there are few active local societies in the United States. Indeed whereas in 1900 there were 72 homeopathic medical colleges in the United States, today there are none. If nothing else homeopathy has had a favorable influence on medicine by calling attention to the dangerousness of the cavalier use of powerful drugs.

#### PERSONAL PROFILE

Dr. Richard Lowkap is a 72 year old, class I, married, Russian Jew, with 5 grandchildren who has practiced homeopathic medicine in New Erehwon for 45 years. He immigrated to Connecticut with his family from Russia at the age of 2. Dr. Lowkap's family of 7-- a mother, a father who worked as a carpenter, 3 sisters and 1 brother-- were financially destitute throughout most of his childhood. The depression years left memories of bitter hardships. Nonetheless, Dr. Lowkap managed to graduate from

an Ivy League school where he stayed for a year in the Department of Zoology and Anatomy working on tissue transplantation. He started medical school in the midst of the depression, but was dramatically told to leave in the midst of an exam and told not to come back until he could pay his tuition. Somehow he managed to graduate with his class in 1930.

After a year's internship in a local hospital, Dr. Lowkap has practiced in a nearby office in New Erehwon for 45 years. Today he appears as a neatly dressed, wistful, soft little man whose face is always tremendously tired and his shoulders stooped. One always has the tragic feeling that he never quite lived life as he wanted to because of an overwhelming sense of responsibility and importance to his patients. He speaks soothingly in grandfatherly tones but is inclined to be forgetful. In contrast to his healing philosophies, his values in general tend to be authoritarian and parochial. The burdens of his practice leave him virtually no time for recreation. He has few friends outside his immediate family and virtually never socializes.

#### Decision to Begin Unorthodox Healing

Dr. Lowkap's motivation to practice medicine began early in life though no one in his family was similarly inclined. His experiences with regular medicine were consistently bad. In particular, he recalls maltreatment by a doctor of a deep laceration which ended in serious infection. Nevertheless, he entered medical school with the hope of learning how to heal.

His keen disillusionment in how little medicine had to offer sick people prompted his study of homeopathy. "I'll never forget the day of my graduation how unhappy I felt. I felt a void. What am I going to do for sick people? Deep inside of me I felt there was something terribly wrong."

During the first year of his practice he began to teach himself homeopathy. At one point, for a year he used to attend, along with a dozen of his colleagues, nearby regular lectures on homeopathy. Aside from these lectures and informal conversations with other Connecticut homeopaths, Dr. Lowkap is entirely self-taught in homeopathy and nutrition. He speaks ruefully of the homeopathic training unexpectedly excluded from his medical education. "They were supposed to teach us homeopathy in the \_\_\_\_\_ medical college, but the AMA threatened to class them a grade B school unless they removed homeopathy from the curriculum. Our one lecturer in homeopathy was suddenly called away to Europe."

#### Attitudes Toward and Knowledge of Scientific Medicine

As a physician, Dr. Lowkap's medical knowledge is clearly superior to that of most unorthodox practitioners, yet he apparently has added little to his scientific training since graduating from medical school. He seldom attends meetings, conferences, courses, etc. They seem to be impossible luxuries under the weight of his busy practice. Nor does he read medical or even homeopathic journals regularly. His reading

instead seems, from his library, to be oriented toward spiritual and philosophical concerns and popular approaches to health problems. Recently, he managed also to take a one week course in Reams therapy, an unorthodox nutritional practice, (cf. Chapter 9) which has profoundly influenced his healing practice. In general though, Dr. Lowkap is much more impressed with what he perceives as the "wisdom" of the past than the knowledge of today.

Dr. Lowkap is highly skeptical of the relevance of many of the practices of orthodox medicine.

I don't think our health has improved much except through sanitation. Cancer and cardiovascular diseases are on the increase, not because of what doctors are doing, but what they're not doing. For example, they have no concern for nutrition. They pay no attention to minerals or vitamins. They hide behind the statement that you get enough in your diet... what makes me feel so disheartened is you go to medical meetings and all these brilliant minds are speaking about disease, not preventive medicine. What we need to do is clean up the world and provide a good diet for everybody. The great vacuum in medicine is first, doctors don't start working until the disease has begun and second, there is a total lack of communication with patients.

Not only are the medical doctors' actions often poorly directed toward promoting health, Dr. Lowkap feels also that allopathic medicines are dangerous. "I don't think the human organism at this point in evolution can handle chemicals. They act as foreign substances and put a tremendous strain on the immune system... I'm not a fanatic, I believe in some drugs, but we shouldn't be so promiscuous with our drugs." For his own health, he claims to have used in his entire life only a few

days of antibiotics, 2 aspirin, 1 shot of demerol and the anesthesia needed for a recent cholecystectomy and prostatectomy.

Dr. Lowkap feels that not only orthodox physicians' pharmacologic practices, but also their relationships with patients leaves much to be desired. Echoing some of his patients' complaints about other doctors, he says that doctors usually charge too much, are impersonal and too hurried in their treatments.

Another type of medicine is needed.

People today are missing the main point that love has healing power. We're (medical professionals) told to keep our distance. Medical doctors should love their patients as their family. To improve medicine what we need to do is to establish a chair called the human side of medicine in medical schools. Medical students should be taught about patient's fears.

He feels that doctors too often dismiss non-specific complaints as psycho-neurosis. In some cases this results in missing an important problem "like hypoglycemia", that can be treated. As for those true psychoneurotics, he feels they can benefit from more understanding and attention.

She (a psychoneurotic) resents being told she's healthy. I do believe them when they say they have pains and discomforts. Even though there's no organic basis, they still suffer from the symptom about which they complain.

He emphasizes that regardless of whether doctors cannot find anything wrong, a patient knows how s/he feels.

A final note concerning Dr. Lowkap's attitudes towards scientific medicine is his definition of a quack. He said, "People should be judged as such only by looking at their results. Without this one must look at their sincerity-- but

then I tend to lean on the positive side and see good in everyone."

#### Religious Affiliations, Beliefs and Practices

Throughout his life, Dr. Lowkap has felt indifferent toward his Jewish heritage. Aside from holy days, he has never been a practicing Jew. In short, religion has meant nothing to him until about five years ago when an Indian medical student interested in Dr. Lowkap's homeopathic practice, persuaded Dr. Lowkap to be initiated into the Eastern sect of Kirpal Singh. Initially involved in the weekly Sat Sangs (the organized religious meetings of the sect), Dr. Lowkap says he has discovered a new profundity in his spiritual life which has given his homeopathic practice new meaning and breadth. Indeed, his healing philosophy, historically neatly confined to the Vitalist category, has more recently taken on some of the attributes of the Perfectionist. Nonetheless, it can be discerned that what he in fact has done is to interpret his Perfectionist experiences and teachings in terms of his Vitalist philosophy. In his words, when "We say God, we mean the body."

Dr. Lowkap now is comfortable with such concepts as reincarnation and karma. He tries to live his belief in 7 (sic) paths to perfection (one of which he forgets!): "Vegetarianism, truthfulness, non-violence, humility, selfless service, Sadhana (ritualistic spiritual practice) and...." The burden of his healing practice has encroached on his ability to continue

weekly Sat Sang and he has stopped meditating because chronic fatigue always prompted sleep. Nevertheless his newly found spiritual appreciation is sustained.

Most broadly he says, "My religion is love." He explicates, "God is within all of us. The soul of all human beings is one. I am you and you are I. We can say I love you to a criminal, it's your conduct I despise. We're all united in one human family." In many ways, he echoes the humanistic scientific philosophy of Rene Dubos (A God Within, 1972) who in spite (or perhaps because of) his rigorous scientific background is a Vitalist in the sense used in this thesis.

#### Illness Beliefs

Dr. Lowkap's spiritual conversion has undeniably affected the way he expresses his beliefs about illness. Indeed, as observed earlier, his spirituality has infused his Vitalist philosophy with a Perfectionist flavor. For example, he says, "On a spiritual basis, there really is no such thing as disease. Disease is not a reality. That's why it can be cured. Disease is a mind that's hypnotized. The real you is perfect and immutable." On the other hand, it is apparent that Dr. Lowkap has really incorporated what to him are new spiritual concepts, into his fundamentally Vitalist philosophy. "Disease is nothing but the expression of a violation of natural law. If we lived according to all the natural laws, there would be no disease." He then goes on to define natural laws as including

"nutritional laws, moral laws, spiritual laws and mental laws" in a typically Vitalist way.

Dr. Lowkap views a person as body, mind and spirit. He sees these aspects of a person as not separate but interrelated, "Usually those who are sick, are sick in mind and spirit too." His multicausal view of illness reflects this perspective. Physical factors like genetic predisposition and nutritional status combine with mental factors like poor attitude (negativistic thinking) and spiritual factors (Karma) to explain why a particular person falls sick.

#### Healing Philosophy and Conception of Health

Dr. Lowkap views the homeopathic techniques he uses as valuable tools, but to clarify his and their role, he says, "I sew the wound, but God heals it." He uses allopathic medicines in a similar way, especially if another physician has prescribed them for an ongoing problem for a patient or if a patient is resistant to the idea of homeopathic remedies. He also is ready to refer patients for more specialized orthodox medical help when either he or his patient is insecure with the technical treatment he is able to offer. Nonetheless, he will repeatedly emphasize that "if you give the human body the proper nutrients (and here he means spiritual, emotional and physical nutrients), it will heal itself."

Dr. Lowkap's healing philosophy reflects his conception of the tripartite view of wo/man. In a statement which manifests

his use of homeopathy as a way of practicing his Vitalist philosophy, he says, "I don't have much faith in promiscuous inoculations. The way I'd prefer it is to teach my patients to build up their own immunization through proper nutrition. Only God heals. No man heals. (And again clarifying) When we say God we mean the body...." Nutritional improvement is not enough. Spiritual development is necessary (for health) as well as emotional and moral development."

Dr. Lowkap sees his primary role as a teacher. He and his techniques are tools to educate the total person about his/her innate healing powers. In the ideal case, he believes "that the wisdom of the body is such that the healthy body can resist disease." Except when he feels that a person would be absolutely refractory, he "always reminds patients of the God within." He teaches that "If you were to develop to be aware of the real you, it (the development) would invoke the healing power. In sum, his healing philosophy is characteristic of the Vitalist and can be symbolized accordingly (○□△).

#### Healer-Patient Relationship: Expectations and Satisfactions

Although he might balk at being called an invaluable healer, there is no doubt that Dr. Lowkap sees himself as an invaluable teacher. He worries constantly about the welfare of his patients and finds it next to impossible to consider taking time off, retiring, or moving out of town. Waxing philosophic, he says, "Sometimes I often wonder whether I am doing justice

to these people (his patients). Am I making these people too dependent on me. What will happen when I go." Indeed his conception of the ideal patient more closely parallels his authoritarian social values than his vitalistic philosophy. He says the good patient is "one who follows instructions, who is anxious to be well and who has faith in the doctor and what he (the patient) has been told to do and one who believes that if he follows his course of therapy he will be well." In spite of these expectations of his relationship with patients, it will be seen that he in fact practices in a manner much more consistent with his healing philosophy.

Dr. Lowkap is a primary care provider and as such expects to be the main source of care for most of his patients. He feels that the majority of his practice is composed of people who have been his patients for years, often decades. A substantial minority of his patients, however, he believes, have been referred to him either through health food stores and other unorthodox healers (eg. chiropractors, nutritional therapists) or by patients satisfied with his particular approach to healing. To his knowledge, no orthodox physician has ever referred a patient to him. He admits that for patients interested in his particular healing philosophy and armamentarium of techniques, there is no other choice in the Greater Erewhon Area.

To Dr. Lowkap, the most important ingredient of his

relationship with patients is compassion. He yearns to convey to patients the feeling that he is intensely interested in their welfare and expects that this is what patients want.

I try to make patients feel that I feel for them. If it's a young boy, I treat him as a son. If he's the same age-- as a brother. If its a female-- as a daughter or sister. I don't make myself feel this way. I really do feel this way. If a father of a young girl in Massachusetts said 'please come'-- you must. I would even leave everything for 10 days. It's not a scientific interest. Oh no, it's beyond that-- it's a human interest. I can feel the agony in their hearts or the glee when they feel their child might get better.

Expectedly, Dr. Lowkap thoroughly appreciates the therapeutic value of his relationship with patients. He aims through this relationship to "treat the whole person, not just the disease."

Dr. Lowkap believes that every person who presents with complaints has a problem amenable to care. "I've never turned a patient away. I've never told a person that their case is hopeless, or that the patient must learn to live with their condition. I believe we can do something."

According to Dr. Lowkap, he has few problems or conflicts with his patients. He feels most people come to him specifically for particular therapies and therefore comply with his prescribed regimens. His major gripe is that people with cancer don't seek him out until they have already been under orthodox treatment for sometime and their malignancies are far advanced. He also sometimes loses his patience with those who do not subscribe to his particular healing philosophy and resist treatment with homeopathy.

## PRACTICE PROFILE

The Day

I spent several days with Dr. Lowkap and was tremendously impressed with how hard he worked. His personal account is, however, more trenchant than mine could be and, if you excuse moments of hyperbole (the hours don't quite add up), generally accurate.

One third of my patients come from out of town crying for help. Cancer patients. I spend an hour with each patient. Sometimes the patients are too ill to come down to New Erehwon. Then I talk to the family for 3/4 of an hour educating them about how to give Laetrile injections IM. I see 15 patients on house calls a day. It takes me 16 hours to see those 15 patients. I get up at 7 a.m. and make phone calls for 2-3 hours from home. From about 10:30 to 4 p.m. I make house calls and hospital visits. At 4 p.m. I go to the office where I work by myself seeing patients and answering the phone until 12:30 or 1 a.m., then I do my paper work. I don't eat all day long except perhaps sometimes a glass of milk and graham crackers at lunch. I don't eat until I go home at 3 a.m. If I were to take time to eat I'd make the poor patients wait that much longer. I'm trying to find someone to help me, but there is no one in this field. I can never really take time off because there is no one to leave my patients to who has the same philosophy of healing. I'm suffering from chronic exhaustion. I know it. I should really take better care of myself, but there is no one to help me with my patients.

In my observation, he worked 18-20 hours a day and spent about one third of his time on the phone, one third on his office practice, and one third on house calls. He had no office hours on the weekend, but scheduled house calls and accepted telephone calls.

### The Patients

One working day from each of 4 weeks during the study month was randomly selected for a survey of Dr. Lowkap's patient population.<sup>2</sup> In the 4 sampled days, he saw a total of 43 patients-- about 10 patients a day. Nineteen (19) of the patients were seen in their own home. One (1) patient was seen in the hospital and 1 in a convalescent home. He spent about 45 minutes with most patients. They ranged in age from 16 to 80 years with an average age of 51. All but 3 patients, who were Black, were non-Hispanic Whites. Thirty-two (32) of the 43 patients were female. Eleven (11) were male. Dr. Lowkap was not able to provide information about both the educational level and occupation of many of his patients. Consequently, the socio-economic distribution of his patients can only be estimated. My impression is that Dr. Lowkap served 3 populations. One group was much older, tended to have been his patients for many years, and usually were of class III or IV. Another group was younger, had just recently begun to consult Dr. Lowkap, and were of class I or II. The third group consisted of cancer patients who consulted Dr. Lowkap specifically for the use of Laetrile. These last patients varied in social class. A rough estimate of the ratio of the numerical size of these three populations would be, respectively 3:2:1. Six (6) of the 43 patients travelled from outside of the Greater Er'ehwon area to consult Dr. Lowkap. Only 4 of the 43 patients

were new to Dr. Lowkap. Of the 39 patients that he had seen before, 31 of them were seen for the same problem they had presented in previous visits. Only 2 patients presented with cancer-- an unusually small number according to Dr. Lowkap. The other problems ranged the gamut of common problems seen by primary care practitioners. Of note, however, 3 healthy patients presented specifically for preventive nutritional counselling. For 13 people, Dr. Lowkap relied on nutritional counselling alone, but all patients received some dietary recommendations. He used orthodox medicines, eg. digoxin, for 11 of the 43 patients. Laetrile was prescribed for (but never given to) 2 cancer patients. Dr. Lowkap explicitly used placebos in 4 cases. In 7 cases, he used homeopathic remedies.

#### Organization of Practice

##### The Place

Dr. Lowkap is truly a solo practitioner. He works alone in an office in an old apartment building. The two small examining rooms, consultation room, and waiting rooms seem hardly enough for the overflowing files, boxes of remedies, old medical instruments, and omnipresent patients. Eschewing secretaries or medical assistants, Dr. Lowkap chooses to battle the unceasing paperwork, telephone calls and patient stream by himself. Disorganization is rampant, but incredible tranquility reigns, Constant telephone interruptions (I counted 14 calls during one hour appointment), misplaced forms and

long patient waits (1-3 hours) are the norm, but do not seem to ruffle the patience of Dr. Lowkap, or in general, his patients. Said one patient after a 2 and a half hour wait, "It's worth it."

Richard is reimbursed by standard third party payers. His charges are low, on a sliding scale, and decided at the moment. They range from no charge to \$20 for an office visit or house call, dependent on Dr. Lowkap's rough judgment of how much the patient can afford to pay. He does not charge for phone calls.

#### Interaction with Other Healers

Dr. Lowkap is on the staff of a local hospital and maintains membership in local and state medical societies as well as the AMA. He attempts to keep a low profile about his unorthodox activities because he has been dressed down by the hospital's medical board and the local medical society a couple of times when it was reported that he was using unconventional techniques. His formal medical privileges have never been suspended. On two occasions, he has testified at the medical board trials of other unorthodox medical doctors.

As noted earlier, Dr. Lowkap is a member of various homeopathic societies, but is relatively inactive. The only real contact he has with other like minded healers is with the nutritional healer discussed in Chapter 9. He serves as the titular medical supervisor for her operations. Otherwise, he does have an active referral structure through which he is sent patients largely from health food stores, nutritionists,

chiropractors and Laetrile supporters and through which he sends patients to spiritual healers as well as the aforementioned varieties.

#### Observations of Practice

Dr. Lowkap's principle therapeutic techniques include homeopathic remedies, nutritional advice, placebos, emotional and spiritual counselling, allopathic medicines and Laetrile. In practice he tended to counsel virtually everyone about decreasing the meat, white flour, and sugar in their diet and increasing the whole grains, raw vegetables and fruits. He also uniformly recommended steamed distilled water for everyone (cf. Chapter 9). Of note too, is that he did often verbally assure people of their self-healing capacities. Interestingly, however, under my observation, he never used the explicit spiritual terminology he often used with me in couching his Vitalist beliefs.

He would always give the patient an elaborately prepared placebo, before he would use either his homeopathic or allopathic medicines. Not infrequently, he did use allopathic medicines, primarily for particular patients who refused homeopathic remedies. These patients seem to try his usually unflappable impatience as he tried to explain his Vitalist philosophy to them. Diagnosis is arrived at by orthodox methods, i.e. physical exam, history, and a minimum of laboratory tests.

Relationship with Patients

The mainstay of his therapeutic approach from an observer's perspective, is his rapport with patients. He made and maintained intimate contact with all of his patients. Without fail he assiduously followed patients-- calling them to make sure all was well and inviting them to call him at any time. Regardless of phone calls, the number of patients in his waiting room, or the hour of the night, Dr. Lowkap always projects the air of having all the time in the world. He is a listener. Gentle in his word and therapy, he aims to please. Sometimes his willingness to comply with patients' desires is apparently to the detriment of appropriate medical practice eg., he asks the patient if s/he wants to undress, have a rectal exam, etc. Apparently too, he is manipulated by neurotic patients incessantly demanding his attention. In short, Dr. Lowkap's relationship with his patients is more closely related to his philosophy of healing than his authoritarian expectations of the relationship implies. His modal professional relationship with patients is an extrapolation of his healing philosophy and can be symbolized as a . Concordant with his healing philosophy, he is the tool of his patients. They are in control. In compliance with the wishes of his patients, he offers techniques with which they can heal themselves.

## IMPRESSION OF PRACTICE

In short, Richard Lowkap is a man with deeply felt Vitalist convictions about and unimaginable dedication to healing people. His philosophy of healing is reflected in his actual social relationship with patients. As a practitioner, in many ways, he resembles the traditional stereotype of the old family doctor-- perhaps outdated in his therapies, disorganized in his practice, but all caring about his patients.

CHAPTER 9

MS. BETTE KIRBO, NUTRITIONAL

AND LAETRILE THERAPIST

Technical (Type VII)

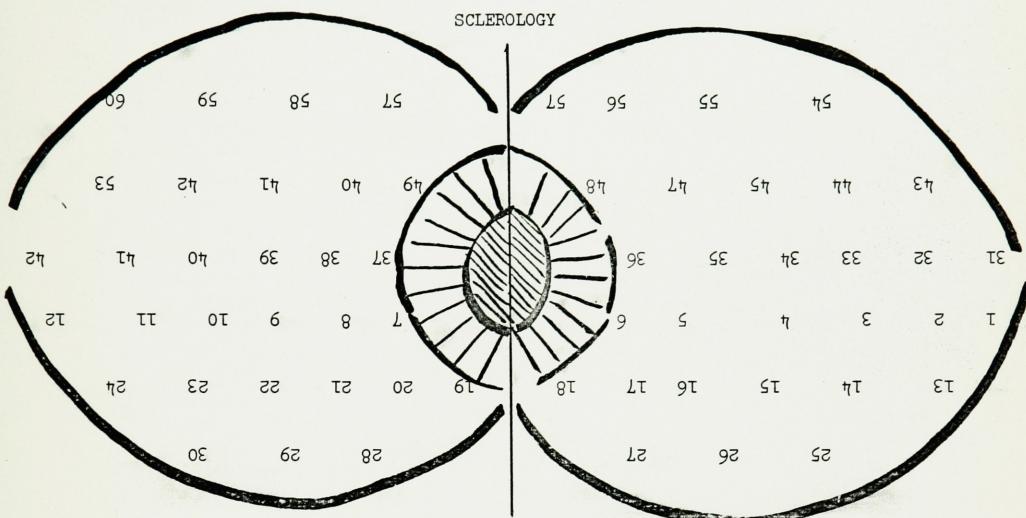
Bette Kirbo is an example of a Technical healer whose therapeutic techniques are based on the use of Laetrile and a particular nutritional regimen called the Ream's Program. Only a fragmentary, popular literature descriptive of the Ream's Program is available. The following brief account is based on some of this material (Davis 1976, Kirban 1976).

#### BACKGROUND OF TECHNIQUE

In the late 1950's, the Reams' Program was developed by a Dr. Reams, who allegedly is an ordained minister and holds degrees in biochemistry and biophysics. His program consists of a dietary prescription based on an analysis of the state of the organism. The data collected to arrive at the "diagnosis" consist of "eye-numbers" and laboratory testing of the urine and saliva. The eye numbers are gathered by the Ream's tester who observes the patient's sclera for the presence and course of blood vessels. Dr. Reams has composed a master map of numbers superimposed on a diagram of the sclera. The numbers correspond to the various organs of the body, (cf. Chart 9A). The person in perfect health would theoretically have no obvious blood vessels in the sclera. By noting the presence and course of vessels, the observer is able to translate the numbers into a "diagnosis" of the diseased or "weakened" organs. The testing of urine and saliva contributes to this diagnosis. The urine is tested for pH, "sugar", total salt content,

CHART 9A

## SCLEROLOGY

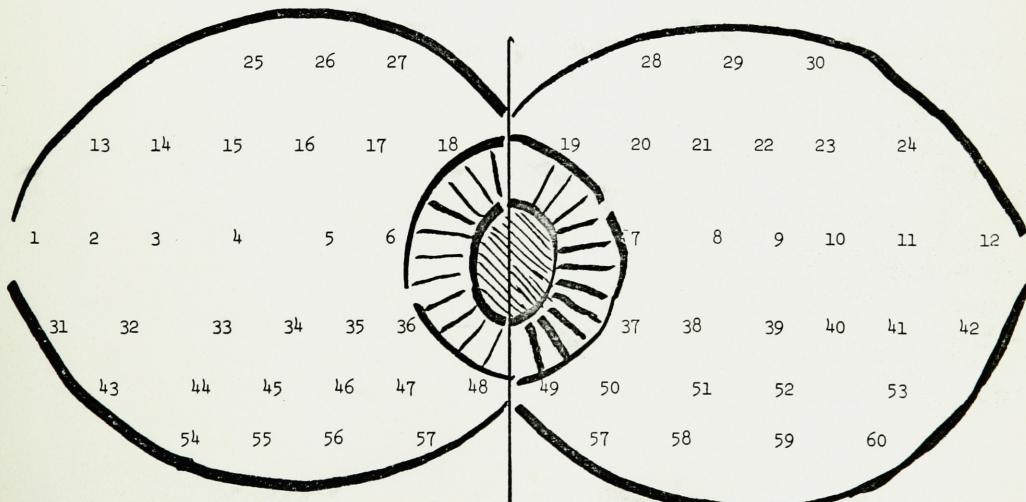


LEFT EYE LOOKING RIGHT

LEFT EYE LOOKING LEFT

RIGHT EYE LOOKING LEFT

RIGHT EYE LOOKING RIGHT



## CHART 9A (Continued)

Eye Numbers (Right eye indicates right side of body; left indicates left side unless otherwise indicated)\*

RIGHT EYE:

- 1 - TRANSVERSE COLON FROM HEPATIC FLEXURE TO NAVEL (1---12)
- 13-15 - LIVER
- 16-17 - LOWER LUNG (rt)
- 18 - 8th DORSAL
- 19 - Shoulder
- 20,21 - Upper lung (Rt.)
- 22 - Starts under armpit and comes to center of breast (lung)
- 23 - Breast (center portion in line with nipple)
- 24 - Slightly to right of center of chest - right over the aorta artery
- 25 - 7th Cervical
- 26 - 3rd and 4th Cervical
- 27 - Atlas
- 28 - Back 1/3 of head
- 29 - Center (over the ear) of head
- 30 - forehead - sinus - eye strain
- 31,33 - Ovary (below Transverse Colon - Females)  
(below Transverse Colon - Males)
- 34,35 - Between Ovary and Spine
- 36 - 5th Lumbar
- 37-42 - 37-Top of Ascending Colon: 41-ileocecal valve with 42 being at appendix
- 43-45 - Kidney
- 46,47 - Floor of Pelvis - Rt. Side
- 48 - Top of Rectal Tube
- 49 - Center of Rectal Tube
- 50 - Anus
- 51,53 - Bladder
- 54,55 - Back of Uterus (Female) Cord and Testicle (Male)
- 55,56 - Prostate
- 56 - Cervix
- 57,58 - Vagina(Female) Penis(Male)
- 59 - Left knee and/or calf of leg
- 60 - Left hip

60 on both right and left indicates arthritis or osteoporotic condition

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\*Only the numbers for the right eye are presented here for the purpose of exemplifying this diagnostic technique. Vessels coursing through these numbers indicate weakened or diseased organs.

albumin ("estimated" by a rough measure of the turbidity of the urine sample) and a ratio of "cationic nitrate nitrogen" over "anionic ammoniacal nitrogen." The numbers obtained from these measurements are used in a "formula" which reflects "the state of the organism." The last test, the pH of the saliva is used to complete this formula, which actually is merely a series of dimensionless numbers.

(Sugar  $\frac{\text{pH urine}}{\text{pH saliva}}$  salt albumin  $\frac{\text{nitrato nitrogen}}{\text{ammoniacal nitrogen}}$  ).

The formula for perfect health is 1.5  $\frac{6.40}{6.40}$  6-7c .04m 3/3. Deviations from this formula are taken as indices of past or currently active disease or of the "susceptibility" of the various body organs to disease.

Each patient in a Ream's Program is prescribed an individualized dietary regimen on the basis of their formula and eye numbers. The regimen is expected to cure and/or prevent incipient disease. The recommended therapy usually consists of an initial fasting period of 3 days when only water and lemon juice are allowed. Subsequently, one of seven basically vegetarian whole grain, raw vegetable and fruit, sugarless diets is prescribed. A number of mineral supplements are suggested. If the patient has cancer, Laetrile is added to the regimen. Additionally, all patients are instructed to drink 4 ounces of steamed distilled water every 30 minutes while awake. No other water may be used.

Dr. Reams has a retreat in Georgia where he has taught

hundreds of people his method. They now practice independently as Ream's testers across the United States. Reams testers contest that they are not practicing medicine without a license. They say that their program consists merely of a number of chemical tests and a discussion of diet. Nevertheless, according to the Reams promoters who are outspokenly anti-medicine, local medical societies have successfully brought legal charges against some "testers" for practicing medicine without a license. Of note also is that an investigative report exposing a Ream's center in California for fraudulent practice was recently broadcast on national television ("Sixty Minutes", CBS 1978).

#### PERSONAL PROFILE

Ms. Bette Kirbo is a 50 year old, class III, divorced, white, registered nurse with 9 children. Her main occupation was until recently running a convalescent home. Born in New England, Ms. Kirbo has lived in the Greater Erehwon area for about 25 years. After graduating first in her class from a Catholic boarding high school, she was pressured by an uncle close to her family into going to a nearby college. Resistant to this pressure, she flunked out of college after her first year to enter directly a local hospital affiliated nursing program.

Ms. Kirbo was raised by a sister. Her mother was a

seriously ill alcoholic and her father died of cancer while she was young. She traces a terror of cancer to having to watch her father die from it. This early experience with illness, along with the fact that her sister was a registered nurse, made nursing her unquestioned career goal. She was married to a small business man, after obtaining her RN. While raising her 9 children, she managed to continue her nursing work in several of the local hospitals. Disillusioned with orthodox medical practice, for reasons described below, she bought a convalescent home in West Erehwon with her husband 4 years ago. At the time, the home was a licensed intermediate care facility with medical supervision and 29 patients. In four years, she has changed the nature of this facility considerably in concordance with the evolution of her own philosophy of healing.

Today, she is a controlled, attractive woman appearing her stated age. She demonstrates a remarkably easy-going facility in managing an enormous household of nine school age children living along with her patients, in a rambling old convalescent home. Having left the orthodox medical fold 4 years ago, and then getting divorced 2 years ago, Ms. Kirbo has experienced a major upheaval in life. Now is a time of new directions for her. She warned me that her thoughts about healing, illness, and spiritual matters are all in a process of change. As part of her search for new perspectives on her life and her work,

she has taken on 2 associates whose ideas and beliefs have begun to influence her own. The evolving, and at times poorly defined nature of her beliefs, must be considered in reviewing her case history.

#### Decision to Begin

Ms. Kirbo always had an aversion to medical doctors. "I've always been funny about MD's. I wouldn't go to a doctor I didn't know, because they're so often pretty cold, not too thorough or concerned." She suggests that her original decision of a nursing career was more a function of family pressure than an active choice on her part. "Everyone assumed that I would be a nurse. I never questioned it."

A number of professional and personal experiences with orthodox medicine has by now "utterly and thoroughly disillusioned (her) with regular medicine." Although never seriously ill, she remembers being set against drugs because of experiences in her own life. "The thing that's got me so hung up about drugs is their side effects. It seems like I'm just one of those people who got an (side) effect from everything."

Ms. Kirbo remembers experiences with her children as being among the most poignant factors which pushed her into unorthodox healing.

I had a severely asthmatic son. I spent \$40 a week on

his medicines but he wasn't getting any better. The money wouldn't have mattered if he was getting better, but he wasn't. I can remember sitting around a mahogany table with a lot of doctors at \_\_\_\_\_ hospital, who said they were going to write him up in a medical journal. About this time, I was talking about Ricky (the asthmatic child) with Dr. Lindsay (who is an MD in a nearby town who has never practiced medicine, but recently has taken an interest in unorthodox healing). She suggested that I read Body, Mind and Sugar by Abramson. The more I read, the more I realized that I had wasted 3 years (in nursing school). I began reading other health food books and became convinced that that was the way to go. I cut Ricky off of all his drugs cold turkey, and began him on a healthy diet with vitamin supplements, and within 3 months he was completely better.

Then we (her family) began getting interested in herbs. My 4 year old daughter scratched her foot on a rusty wire hanger-- I had never let her see a doctor (including for immunizations). Overnight her foot swelled up and a red streak travelled up to her groin. I knew right then that I'd have to decide whether or not to go along with this whole thing (alternative methods of healing). I decided not to take her to the ER and soaked her foot in a tub of comfrey (an herb). It cleared completely in a day.

Four years ago, on the strength of personal experiences like these, as well as a dislike of hospital practices, she decided, with her husband, to buy a convalescent home in West Erehwon. Her intention was to practice a different sort of medicine.

At that point it was a licensed ICF (Intermediate Care Facility) with medical supervision and 29 patients. All patients were on Seconal, tranquilizers and milk of magnesia and of course were eating junk food. We started them on a health diet-- no white flour or sugar, lots of vegetables and whole grains etc., and we were able to get them off of all drugs. We never let a podiatrist in the place. We got rid of all the corns with long soaks of yellow soap and careful scraping.

After her divorce, Ms. Kirbo pursued her interests in unorthodox healing more intensively. While at an annual

meeting of a local chapter of the Nutritional Foods Association (cf. p.78 ), Ms. Kirbo was told of the Reams program. She took her first Reams course in August of 1976 and then worked at the Reams retreat in Georgia for two weeks.<sup>1</sup>

Her Reams training consists of chemical theory and practical experience in using laboratory equipment in interpreting the results. Since her initial 5 day course, she has returned 5 times for 1 week sessions of more advanced training. The complete course consists of 9 one week classes. She has not completed the course because of its tremendous expense. Each week costs \$500. The requisite laboratory equipment which is sold at the Reams center is also quite expensive. Indeed, Ms. Kirbo says that the whole operation has become a money making affair since an entrepreneur bought out Dr. Reams' share of the corporation.

There is no formal testing or certification of a person's knowledge of Reams theory. Ms. Kirbo, subsequent to her first trip to the Georgia retreat, turned in her convalescent home license and established the home as a Reams center. (Recently she eschews the name Reams because of what she feels has become the profit grubbing aspects of the central organization).

Even so, Ms. Kirbo is often insecure about her minimal nutritional training. The remainder of her formal training in unorthodox healing has been restricted to a week long course in iridology (the science of iris diagnosis).

Attitudes Toward and Knowledge of Scientific Medicine

Of all the healers I contacted and/or talked with intensively, Ms. Kirbo is by far the most hostile toward scientific medicine. When asked to define a quack she said, "I am beginning to think that ND's are the quacks." Although she concedes that doctors are absolutely essential for treating trauma, she sees little other use for them. She has not had any of her children immunized because of her conviction that most of medical practice is harmful. She is particularly disturbed that "doctors don't know anything about nutrition. They never go for the cause. They treat the symptom. They reach for drugs instead of reaching for something natural. Why can't they see the results of good nutrition?"

Currently, Ms. Kirbo admits she is just getting over a very bitter period in her feelings for doctors. The reason for the profundity of this bitterness is not immediately clear from what she has told me, but it seems to go beyond a simple intellectual difference of opinion. Without having all the information, it is possible to speculate that experience with doctors during her father's evidently long agonizing death from cancer, combined with her total hysterectomy 4 years ago, a benign breast biopsy 2 years ago (both occurring at a time of

turmoil with her husband) and poor experiences with medical care for her children, contributed to this bitterness.

Although Ms. Kirbo was quick to remind me that she had had orthodox medical training and experience, her knowledge of scientific medicine was shallow. She did have a good grasp of the symptoms of different stages of diabetes mellitus and of an acute myocardial infarction. Of considerable interest, however, is that she was able to remember only 3 of the 7 classic early warning signs of cancer (Joe Carbonella, a lay person, remembered all 7 and then some.) Cancer is apparently an area with which she is very uncomfortable. That she has chosen to treat cancer patients with unorthodox treatments is all the more interesting.

#### Religious Affiliations, Beliefs and Practices

Ms. Kirbo was born into the Congregational church, confirmed in a high Episcopal church and then educated in a Catholic boarding school and nursing school. She feels completely removed from any of these religious experiences and currently has no church affiliations. Privately, however, she has maintained a vague belief in a higher power which provides a purpose to life. She believes that the higher power is responsible for creating herbs that heal. Otherwise, spiritual matters have been of little concern to her until her recent association (3 months ago) with 2 psychic healers, whose beliefs are consistent with those outlined for the

Spiritual healer (p. 69). She says,

I am just beginning to think about higher powers. Inviting Dick (the psychic healer) to join me is an important part of my search.

Since this association, she has begun to believe that "a higher power is part of healing, but I don't know how except that I know that there is a connection with the attitude of the patient."

#### Illness Beliefs

Ms. Kirbo's beliefs about illness epitomize those of other unorthodox Technical healers. Her beliefs reflect an alternative theory of disease which directly conflicts with the biomedical model. Ms. Kirbo's theory of disease is couched in the same classic triad of agent, environment and host that the medical model uses. She sees the primary offending agents of disease as toxins. "...When I say that, I'm fully aware of what I was taught in my training-- that years ago people believed that vapors caused disease. I think we're going back to that time (in our beliefs)." When asked what she meant by toxins, she provided an example. "Take a hamburger. Cook it. Put it in a nice warm atmosphere for 24 hours. You end up with putrid meat. That is exactly what happens in the colon... I don't pretend to understand the chemistry of it, but toxins are absorbed through the stagnant bowel." Ms. Kirbo does cite other agents of disease. For example, she believes that "cancer is a microbe." Ultimately,

however, she believes that the particular manifestation of a disease in a person is a function of modifying environmental and host factors.

The reasons for getting sick are pretty much the same, but they are manifested differently in different people depending on what kind of person it is-- that is what kind of work they do, their sun sign, etc., and then (nutritional) deficiency patterns.

She says, for example, that the locus of a primary malignant lesion is determined by "the kind of deficiency patterns you have. The microbe that causes cancer will settle and be activated in the area of deficiency."

Different problems have different kinds of nutritional deficiencies which can be discerned and treated by the Reams method. Although there are characteristic Reams formulas (cf. p. 174), i.e. one formula might indicate a person has a carcinoma in the descending colon, Ms. Kirbo resists putting names on diseases. One of the reasons is "because the treatment is pretty much the same-- detoxification no matter what the problem is." There are differences in the supplements or diets used, but these differences are not due to what kind of "disease" the patients have. More important are the kind of deficiencies they have.

Perhaps another reason behind her semantic distinction between "nutritional analysis" and diagnosis is that the latter would convey the impression that she is practicing medicine illegally. In our discussions, she vacillates in

her willingness to broach this topic.

#### Conception of Health

Ms. Kirbo conceives of health as something more than a feeling state. She believes that various laboratory techniques are needed to more accurately assess a person's health.

The standard is that health is a symptom free state, but that doesn't mean you're healthy. It only means you feel healthy. In order to really know you're healthy, you'd need something even more elaborate than the Reams testing (she mentions various other unorthodox testing techniques).

As could be predicted, she believes that a proper diet in combination with exercise and regular relaxation is the single most important factor in maintaining one's health.

#### Healing Philosophy

As a function of her association with two psychic healers, Ms. Kirbo has begun to consider the possibility that there is a higher power whose presence is healing. Her considerations are based purely on her empirical observation of the efficacy of psychic healing. "There's got to be something to it, because it gets results." Her fascination, apparently is more with the technique than what it might imply about universal energies. "At the bottom line, what's the difference as long as something works."

In the final analysis, Ms. Kirbo views healing as an equally shared responsibility of the healer and the patient. She sees herself as a source of expert technical assistance.

The patient has the responsibility in taking her advice. Healing will occur with the application of appropriate techniques. If a person supplies his/her "body with the right raw materials, and therefore the right amount of energy to go ahead, (it will) do its thing (heal itself)." She acknowledges, however, that there is "no way you can help someone unless a person develops interest in the nutritional method and will help themselves. I'm not going to push anything down anyone's throat. They've got to do it for themselves... I tell them 'Either go or get off the pot.' We can only assist." Her techniques, however valuable they are, can only work in the proper setting-- a patient who is willing to take seriously their role in the healing.

I've become more and more impressed that attitude is the key factor-- even more important than the Laetrile itself. I realized that if a person climbs into bed, settles down and asks to have the Laetrile given to him as if it would make him better, it wouldn't work.

Ms. Kirbo readily admits that not everyone gets better. In general, she feels that "people get better in a direct relationship to how well they stick to their diet though their attitude is also crucial." If she is certain that the patient is playing his/her role, she will use another nutritional approach and/or refer the patient to a healer who can apply another technique, eg. psychic healing.

In sum, Ms. Kirbo's healing philosophy is Technical. She is beginning to consider the role of a higher power in healing.

At this point however, she is more clearly impressed by the techniques that are employed by other categories of healers than their philosophical explanation. The key point is that she does not feel that her practice of healing hinges on the presence of a higher power. She considers her role of a healer as one of a coach who helps players run their own races. This philosophy can be symbolized as  $\square \triangle$ .

#### Healer-Patient Relationship: Expectations and Satisfactions

Ms. Kirbo expects to be the primary source of health care for most people who come to her. She will not, however, assume the responsibility of deciding whether a patient should discontinue orthodox care. She finds that her patients have usually gone the full medical route, and are now willing to try anything if it's "non-toxic." Ms. Kirbo feels (and perhaps desires?) that people treat her as if she were a doctor. "It's hard to impress people that I'm not a doctor and that I can't make a diagnosis. As long as people have made an absolute commitment not to use other methods, I just do the best I can nutritionally."

Ms. Kirbo believes that patients are looking for more than an efficacious technique. They are also seeking a healer who cares. For this reason, she tries to be friendly with her patients. As a nutritional healer, however, she sees her chief role as an educator. In general, she finds her patients to be eager students. She derives great satisfaction from

assisting patients who are anxious to help themselves, but is frustrated by "those who expect that I will do it for them." To her dismay, she recounts that many "people don't drink their distilled water. They cheat on their diet and don't read the diet book. People expect to come and be cured and don't realize that it's them who have to do the healing."

#### PRACTICE PROFILE

##### The Day, The Patients

Normally, Ms. Kirbo worked a full eight hour day.<sup>2</sup> She spent about 1 hour with new out-patients and 1/2 hour with patients she had already seen. Accordingly, she usually saw 8-12 out-patients per day, Monday through Friday. On one day, she recorded 18 calls from patients. For the 3 randomly selected work days during the study month, however, she worked with a total of only 6 out-patients. On one of these 3 days, she saw no patients. The 6 patients seen ranged in age from 24 to 70 years. All were white and in classes I, II, or III. Two (2) of the 6 patients were male. Ms. Kirbo had only seen 2 of the 6 patients previously. All of the patients had been referred by other patients. Four (4) of the patients travelled from distances outside of the Greater Erehwon Area. All but 1 of the patients had been seen (for their present problems) by numerous (as many as 7) physicians. These problems included chronic bladder infections, malaise, fatigue, constipation, dermatologic conditions, and obesity. For all

of these problems, the Ream's program was prescribed.

As mentioned previously, Ms. Kirbo's practice also included in-patient treatment. Five (5) patients lived permanently in the home. They were people who had first moved into the home when it functioned as an intermediate care facility. They were all mildly retarded. Ms. Kirbo was paid by medicare or medicaid for providing a sheltered living arrangement for them. None of them were involved in the Reams program.

Besides these 5 patients, there usually were 2-3 in-patients who were involved in the Reams program. They had often travelled great distances-- hundreds, even thousands, of miles. About half of these people presented no specific medical problems. They had come for "detoxification" with the hope of alleviating vague symptoms like fatigue or malaise. The remainder of the patients usually had grave medical problems, like cancer, which had been refractory to orthodox medical treatment.

#### Organization of Practice

##### The Place

Ms. Kirbo practices in an enormous rambling old convalescent home on the beach in West Erehwon. She lives in the home with her children who help her with the day to day chores of her healing practice. About 2/3 of the space which was once devoted to nursing home residents is now used for office space, consultation rooms and laboratory equipment. The laboratory where Ms. Kirbo does most of her testing is cluttered with

chemicals, uncomplicated laboratory equipment and huge color posters of eyes. Another prominent area in the house is the kitchen which is well stocked with health foods and equipment such as juice extractors.

#### Interaction With Other Healers

Ms. Kirbo runs her practice with the assistance of two other testers she has trained; her daughter and a psychic healer. At this time, her practice is largely separate from that of the two psychic healers to whom she offered office space. Increasingly, however, the healers are referring patients to each other and the ultimate aim is an alternative polyclinic. Dr. Lowkap (Chapter 8) serves as the nominal medical supervisor of the operation. In fact, he rarely finds time from his practice to visit the "clinic". His main function now is to sign the affidavits which patients need to legally obtain the Laetrile that Ms. Kirbo injects them with.

Ms. Kirbo has an active referral system with the other Type V and VII unorthodox healers. There are only two other Reams testers in Connecticut to her knowledge. Consequently, many health food stores, chiropractors, homeopaths, ect. who believe in the Reams Program send people to Ms. Kirbo. In turn, Ms. Kirbo refers to other healers patients who have been refractory to her methods. On occasion she will strongly recommend that a patient be followed medically for physiological monitoring of a disease process or when an acute life

threatening event supervenes (eg. massive hemorrhaging).

"I do recommend a hospital if we've hit the end of the line nutritionally."

She currently maintains no affiliation with the Reams organization or with other testers because they have begun "trying to make a fast buck." In this self-imposed isolation, she confesses that she feels "too much on my own. I don't feel I have enough of a background." She is, however, a part of a growing loose association of Laetrile supporters who consistently supply her with patients.

#### Interaction with Orthodox Medicine

Ms. Kirbo is determined in her support of unorthodox healing practices-- though she feels she is putting her "head in a noose." She is well aware of her precarious legal status. Consequently, she attempts to keep a very low profile for her practice. She knows that the town health department is cognizant of her medical activities, including her use of Laetrile. Once the department sent a nurse to investigate. So far, no legal actions have been taken.

#### OBSERVATIONS OF PRACTICE

The mainstays of Ms. Kirbo's therapeutic and "diagnostic" armamentarium are the Reams Program and Laetrile. More recently however, she has added iridology to her analytic skills. Iridology presumes that there is a homunculus mapped on the

iris. By observing characteristic changes at particular locations in the iris, one can surmise that the corresponding organ systems are malfunctioning. She also has begun to adapt the basic Reams diet on the basis of her own empirical experience. In effect, her practice is very eclectic. She is willing to try any unorthodox method.

The first testing of a patient takes about one hour. After the testing of urine and saliva, and a study of the eyes, Ms. Kirbo presents her patient with the derived Reams formula. She spends the larger part of this first appointment explaining the Reams program and clarifying the patient's dietary prescription. She always offers the patient the decision about electing in-patient treatment (essentially for the benefit of the supportive atmosphere) or out-patient treatment. In-patients are tested twice daily, but otherwise are simply expected to relax and abide by the diet which is prepared for them. Out-patients are expected to return for re-testing in one month and then at subsequent intervals depending on their progress. Progress is measured by how people feel and how closely their Reams numbers approximate the "perfect formula of health" (p.174). All patients are also warned that as they begin to "de-toxify", they initially will suffer an acute exacerbation of whatever problem is bothering them.

Cancer patients arrive at Ms. Kirbo's office with their

own parenteral Laetrile which she injects intravenously. All of these patients are also on the Reams program. Depending on the stage of intravenous treatment, they may come as frequently as every day.

Ms. Kirbo maintains that the cost of her professional service is less than any other Reams tester in the country. She charges \$35 for the first test, \$12 for a retest, and \$225 per week of in-patient services. There is no charge for Laetrile injections or telephone advice. Records are kept for each patient she treats.

#### IMPRESSIONS OF PRACTICE

Ms. Kirbo's practice was striking in its similarity to some doctor's practices. Like a doctor, she is privy to a mass of information not easily accessible to the lay person. The emphasis of the Reams theory and its dietary prescription was obviously intimidating to many of her patients. Under my observation, she tended to use technical concepts and terms freely, without adequate explanation, in her conversations with patients. Dietary prescriptions were complicated. The mineral supplements had strange names and were expensive to fill. As she herself observed, people did tend to treat her as if she were a doctor. Her patients depended on her for advice which she admitted sometimes went beyond her professional expertise. Nonetheless, her power to impress her patients was

considerably enhanced by the analytic techniques she used. Without taking a history, she was able, on many occasions, to tell patients exactly what bothered them. Allegedly, she used only her Reams numbers to do this.<sup>3</sup>

On occasion, her relationship with patients met her ideal of a cooperative endeavor (█▲). More frequently, to her obvious dissatisfaction, she found herself in the role of reprimanding her patients like naughty children for cheating on their diets (█▲). Like a physician using blood levels to monitor compliance, Ms. Kirbo purported to be able to follow a person's compliance with a diet on the basis of their Reams numbers. Significantly a person's state of health was monitored not only by an assessment of a person's feeling state, but also by laboratory investigation. A person could feel healthy and yet be told by Ms. Kirbo that they had, or were at risk of serious medical problems, eg. cancer of the colon.

In my experience, Ms. Kirbo appeared to offer considerable non-specific support for motivated patients. She actively encouraged her patients' efforts to take their health into their own hands. She was often the willing friend with nutritional advice and connections to obtain Laetrile. Her door was always open and her house had a warm relaxed atmosphere. She was generous with her time on the telephone. Yet, never did I observe Ms. Kirbo interact with her patients on a deeply emotional level, or on a spiritual one. Interactions

were restricted to technical questions and answers or relatively superficial friendliness. She was not a listener, nor even an inquirer.

Ms. Kirbo projected a much different impression of herself as a healer than did the healers of other philosophical categories. With the other healers, I was always impressed with their presence. They acted as if they had a special gift-- as if they had no question that their actions or mere presence were healing. Ms. Kirbo acted the part of the able mechanic. Any appropriately trained person could supply the advice. To her, her presence in and of itself was not healing. In part, this impression may be due to her relative inexperience as a healer or her inner doubts about herself or the efficacy of her treatments. I cannot help but speculate, however, that this difference between Ms. Kirbo and the healers in lower numbered philosophical categories, might be due to the fact that her practice did not hinge on the presence of a higher power.

CHAPTER 10

HEALING THEMES: THE HEALER AND THE HEALING RELATIONSHIP

The case studies are rich with material relevant to understanding unorthodox healing and illness behavior. Two themes omnipresent throughout these histories were the concept of a "healing presence" and the existence of different types of healer-patient relationships. These two subjects are more fully developed in this chapter. Other salient factors that have emerged about healers and are related to patient decision making are reviewed with the patient data in Chapter 13.

#### THE HEALING PRESENCE

There is a great deal of literature devoted to documenting the importance most patients place on the personal attributes of their physicians (McKinlay, 1972). This literature is concerned with such qualities as warmth, concern, patience etc.-- qualities that most people would probably want in any person with whom they shared intimate aspects of their life.

Three of the sample healers claim another more special attribute that can be called a healing presence (as opposed to skill). In my experience, beyond a time-honored respect of the therapeutic value of a "good" doctor-patient relationship, doctors do not usually ascribe their medical successes to a unique personal gift of healing. As Technical healers, doctors, in general, focus on the skilled application of techniques that anyone, given the appropriate aptitude, and training, could implement. In this regard, it is the unique relationship that healers I, III and IV (hereafter, the "gifted

healers") purport to have with a higher power that distinguishes them from healers V and VII (hereafter, the "ordinary healers"), as well as from doctors. It was pointed out in the presentation of the patient data (Chapter 11), that the "special" healing presences of healers is for many patients a prime attraction to unorthodox care. As also indicated, I too observed a difference in the presence of the gifted and the ordinary healers. Fabrega (1974) found no group differences in the medical knowledge of lay subjects in certain folk settings from that of healers. Beliefs about the cause and treatment of illness were shared among all the members of the culture. He points out that this system contrasts sharply with our culture, where the difference in knowledge between lay persons and physicians is very large. In the United States these differences probably again disappear between healers in categories I, II, III and IV and their patients. Fabrega's conclusion, which probably pertain to the gifted healers, is that it appears that the role of the healer (his social and spiritual validation), and his charisma, are what give him and his activities credibility, and stamp him as unique in the culture.

Unusual personality characteristics of "native healers," "medicine men" and shamans have long piqued the interest of travellers, missionaries, and behavioral scientists alike. A theme dominating the literature is whether shamans (healers who claim a special gift) are socially deviant persons with an underlying psychotic personality

whose pathology is concealed by the behavioral requirements of their role (Fabrega 1974). Evidence has been reported which supports both the normalcy and the pathology of healers (Fabrega 1973, 1974)

The issue of psychological status then, has been a persistent question in the investigation of all healers who claim a divine gift of healing. Neither Ms. Kirbo nor Dr. Lowkap made such claims. These healers also were not troubled in their roles as healers. Of the gifted healers, however, two, (I and III) had at one time been seriously psychologically disturbed and under the care of a psychiatrist. The third (IV) might presently be considered by some as having psychotic tendencies. Upon discovering their healing gifts, the gifted healers had further problems stemming from a conflict about what was doing the healing. On one hand, they believed that the healing power was greater than them and that, at most, they were conduits for this energy. On the other hand, these healers would struggle with their feelings, supported by their patients, that the healers were responsible for healings. Philosophically wanting to downplay their egos in the healing process, the gifted healers nevertheless found their work ego-inflating.

The "recruitment" and preparation of the gifted healers is one factor distinguishing them from the ordinary healers. All subject healers had had remarkable past medical or personal experiences which prompted their entry into unorthodox healing. The gifted healers, however, were unique in that they believed they had been "called" to heal. Because of some profound mystical or

spiritual experiences, each felt that they had been given special access to the healing energies of a high power. They did not necessarily feel that they had earned this unique relationships (at least in this lifetime). They understood their work as a "calling," not a profession. They could not have gone to school to learn what they know, though it could perhaps be conveyed on the basis of discipleship (Dev Singh). This sense of a gift of healing contributed to their personal conflict about their own role in the healing process (cf. above).

Another aspect of the healing presence of the gifted healers is that they believed strongly that the healer him/herself must be "healthy" to heal. This prerequisite was not only for the benefit of their patients, but also for the healers' own protection. The special healers believed that part of their role involved a deep identification with their afflicted patient. They felt that without a very special kind of preparation they would not be able to do this safely. An "unhealthy," "psychically imbalanced," or "aurically weak" person would not only be unable to help his/her patients, but would him/herself acquire the diseases of his/her patients. (Note the similarity to psychoanalytic training).

All people who work with the sick are exposed to potentially harmful psychological and physical insults. Many orthodox professionals can, to their satisfaction, deal with this problem by modulating the physical and psychological distance between them and their patients.

Ms. Kirbo, also a Technical healer, takes this route and can practice unscathed. It was pointed out that Dr. Lowkap was committed to deeply identifying with his patients. He, however, had not had the benefit of the kind of preparation the special healers had had.

I have already remarked (Chapter 8) that I was impressed that he seemed to carry the weight of the world on his shoulders-- that he had acquired much of the pain and suffering that his patients brought to him. His recent spiritual conversion may be part of an attempt to more "safely" conduct his practice.

Many case studies exist in the literature which document the joy and burden of realizing one has healing power (Fabrega 1974). These studies reiterate what has been learned from the gifted healers presented in this thesis. One published account which summarizes and gives perspective to the gift of healing is a remarkable letter written by a Spanish conquistadore, Nunez Cabeza de Vaca, to his King in 1528 (Long, 1951). It is the story of his shipwreck and capture of himself and a handful of colleagues by American Indians. In brief, the Spaniards are told to heal sick Indians or risk being killed. To the Spaniards' amazement, they do heal. Nunez writes of this realization,

Truly, it was to our amazement that the ailing said they were well. Being Europenas, we thought we had given away to doctors and priests our ability to heal. But here it was, still in our possession, even if we had only Indians to exercise it upon. It was ours after all, we were more than we had thought we were.

...and in the effort of praying I have felt as though something in me had broken, to give me the power of healing.

I told them (his colleagues) we ought not to be self-conscious with one another. That power we had felt flowing in us and through us could not, in the nature of things, be acutely conscious of us as individuals. It must come rather as wind comes to the trees of a forest, or as the ocean continues to murmur in the seashell it has thrown ashore.

...upon me it was dawning only slowly that I had it in my discretion to grant life and health to others...

It was a drunkeness, this feeling I began to have of power to render life and happiness to others. Yet, I was concerned about it. The concern was the important thing - not the wondering about the nature of the power, how widespread it might be, how deep, whether Andrés or Alonso or Estevancio had it in equal measure with me. What occupied me was whether I myself knew how to use it, whether I could master - perhaps being a self-directing power that came through me. But after one accustomed oneself to the idea, it is good to be able to give out health and joy whether one man have it, or whether we all have it.

#### THE HEALING RELATIONSHIP

Szasz (1956) has said that our "...preconceptions of what disease, treatment, and cure are, have a profound bearing on the theory and practice of medicine." In short, what Szasz goes on to propose is that different conceptions of disease, treatment and cure imply different ways of sharing control in a doctor-patient relationship. On the basis of the case studies, I suggest that a healer's philosophy of healing similarly influences his/her behavior with patients. The significance of this influence is that patient

expectations of a healer may in part be based on the healer's philosophy of healing. Patient satisfaction is known, to partially, be a function of fulfilled expectations (Francis 1969, Korsch 1968, McKinlay 1972) and to ultimately affect patient behavior. A theory which could help predict and explain patients' choice of healer, as well as subsequent satisfaction, would help considerably in understanding illness and sick role behavior.

To begin, three types of healer-patient relationships are proposed as extrapolations of the relative roles of the healer, patient, and higher power in a healing philosophy. For consistency, a square (■) and a triangle (▲) are again used to respectively symbolize healer and patient (Chart 10A).<sup>1</sup> In the first type of relationship, the healer is in the position of control and responsibility (■ ▲). Either the healer does something to the patient or the patient is expected to passively comply with the healers' recommendations. Technical healers, such as a hypnotherapist, and their patients would be expected to exemplify this model. In the second type of relationship, healer and patient share responsibility and control (■ ▲). Their interaction is one of mutual participation. Healers from Fundamentalist and Charismatic categories would be expected to fulfill this role with their patients. The patient is more dominant than the healer in the third type of interaction (▲ ■). In an ideal extrapolation of the healing philosophies, Spiritual, Vitalist, and Orthodox Religious practitioners would be expected to relate to their patients in this fashion.

CHART 10A

## IDEAL HEALER-PATIENT RELATIONSHIP BASED ON HEALING PHILOSOPHY\*

PHILOSOPHY	ROLE IN HEALING PROCESS	IDEAL HEALER-PATIENT RELATIONSHIP
I FUNDAMENTALIST	○ □ △	▨ ▲
III PERFECTIONIST	○ □ △	▨ ▲
IV SPIRITUAL	○ □ △	▨ ▲
V VITALIST	○ □ △	▨ ▲
VII TECHNICAL	□ △	▨ ▲

\*SEE TEXT FOR EXPLANATION

Rationale

There are two aspects to the argument that a healer's healing philosophy is a major determinant of his/her relationship with patients. First, healing philosophies as defined in this study, are directly related to conceptions of disease, treatment and cure. Second, different conceptions of disease, treatment and cure imply different types of healer-patient relationships. The conclusion then, will be that a particular philosophy of healing implies a certain type of relationship.

The case studies of healers all confirm the first point. For example, Mr. Carbonella is a Fundamentalist. He believes that God has the primary role in healing. The healer and patient are both equally passive relative to his power. Similarly, he believes that disease is a function of God's will. Treatment consists of a healer directing God's healing energy toward a patient. The healer is "special" in his ability to do this directing, but this ability is a "gift" from God. Theoretically the gift is truly a gift and is primarily due to God's grace, rather than the merit of the recipient.<sup>2</sup> Finally, the Fundamentalist healing philosophy implies, as is the case with Mr. Carbonella, that a "cure" involves a patient's acceptance of God's will, more than a literal curing of a disease.

The next point is also drawn from the case studies of the healer, but mirrors Szasz' argument. Ms. Kirbo, a Technical healer, believes that "cancer is a microbe." It settles in a particular location in a body due to the kind of "(nutritional) deficiency patterns you have." In short, she believes that disease is a thing. What is more, she believes that a drug, (Laetrile), along with a nutritional program, can eradicate it. Some of her patients are dependent on her for intravenous Laetrile injections (█ A). On the other hand, Dr. Lowkap, a Vitalist, believes that disease is due to a patient's transgression of a natural law. Dr. Lowkap's treatments are not weapons he wields in a battle against disease. Rather, they are gentle "reminders" to the patient about the wisdom of his/her body. Dr. Lowkap counsels patients or prescribes homeopathic remedies which are meant to stimulate the patient's own healing processes. These treatments do not require the dependency of the patients. The patients share responsibility in treatment (eg. the talking aspects) or are primarily responsible for effecting a treatment, eg. drinking distilled water. These "treatments" theoretically allow for an equal (█ A) or even a patient dominant relationship with a healer ( A). Mr. Carbonella's philosophy of healing equally de-emphasizes the role that healer and patient play. His techniques, primarily prayer, create no dependency in themselves. He touches, talks and prays with patients (█ A) in the hope that God will beneficially affect the patients' outcomes. (Other factors sometimes distort this relationship as indicated below).

In the "ideal" case, then, the healer-patient relationship perfectly reflects the healing philosophy. Obviously, as pointed out in the healers' case studies, this reflection is imperfect. For example, Mr. Gaudio's interaction with most of his patients was characterized as  , in spite of the ideal extrapolation of his healing philosophy  .

Four principal factors are suggested which mediate the way that a healer might be expected to practice his/her philosophy of healing. Unquestionably, there are more, eg. past experiences of healer and patient. These four are reviewed because of their particular relevance to this thesis. Together all of these factors ultimately determine how a healing philosophy is translated into practice. Each individually tends to disturb the "ideal" relationship in a predictable manner. The first factor involves the personalities of the healer and patient. For example, the "activated" male patient with angina who is interested in maintaining some control of his health care may seek several opinions before consenting to coronary by-pass surgery from a surgeon of his choosing. This patient has gained some control, but because of the nature of the treatment process itself, he, in the final analysis, must remain passive relative to the surgeon ( ). On the other hand, if this patient, with a different conception of his problem had sought help from a Vitalist healer such as Dr. Lowkap, he could easily have become dominant relative to the healer ( ). Mr. Gaudio is an example of how a healer's personality strongly influenced his

practice with patients. Psychic healing, however, does not, in itself give the healer as much control of a patient as does surgery. In fact, all patients who desired, were able to achieve a dominant relationship with Mr. Gaudio (see p. 269), the Patient Role). Also to be mentioned is the effect of a healer feeling "gifted." The sense of being special as described in the first section of this chapter tended to magnify the role of a healer with a patient.

The second factor affecting the way that a healer practices his/her philosophy is the type and stage of problem that the patient presents to the healer. For example, the patient who is brought into the emergency room unconscious after an automobile accident will necessarily relate passively to this physician (█▲). Similarly, as pointed out in Chapter 11, a depressed, helpless, severely Parkinsonian patient of Mr. Gaudio's (patient IVC) could not relate to anyone except in a passive manner. The same accident victim who awakens to find that his only injury is a broken leg will now be expected by his physician to take a more active, though still compliant role during rehabilitation (█▲). Similarly, Mr. Carbonella's relationship with patients changed depending on the nature and stage of their problem. For example, as noted in Chapter 5, his healing relationship with an unconscious patient who had a brain tumor was more dominant than with a patient suffering from a simple leg fracture. Further, throughout their long recovery, patients would gradually assume a more equal role with Mr. Carbonella. Over the course of a hospitalization, Mr. Carbonella would gradually make

his faith healing activities known. Initially, he might be "healing" without the consent or knowledge of his patients (■▲). As he made himself known, his patients would participate through prayer, positive attitude (■▲) etc. A key point to be further examined with reference to the patient data, is made by Szasz (1956). He notes that if a relationship does not change accordingly throughout the different stages of a disease process, the patient and/or healer may dissolve the relationship.

A third factor which modifies a healer's "ideal" relationship with his patients, is his/her position in the patient's referral structure (cf. p. 70). As long as the patient is within the lay referral system, s/he maintains control of the healer-patient relationship by deciding who to consult. Once s/he has consulted a professional medical practitioner, it becomes the physician's function to refer to other practitioners if necessary. Freidson (1972) states:

When he first feels ill, the patient thinks he is competent to judge whether he is actually ill and what general class of illness it is. On this basis, he treats himself. Failure of his initial prescription leads him into the lay referral structure, and the failure of other lay prescriptions leads him to the physician. Upon this preliminary career of failures the practical authority of the physician rests, though it must be remembered that the client may still think he knows what is wrong with him.

This movement through the lay referral system is predicated upon the client's conception of what he needs. The practitioner standing at the apex of the lay referral system is the last consultant chosen on the basis of those lay conceptions. When that chosen practitioner cannot himself handle the problem, it becomes his function, not that of the patient or his lay consultants, to refer to another practitioner. At this point the professional referral system

is entered. Choice, and therefore positive control, it now taken out of the hands of the client and comes to rest in the hands of the practitioner, and the use of professional services is not longer predicated on the client's lay understanding - indeed, the client may be given services for which he did not ask, whose rationale is beyond him. Obviously, the patient by now is relatively helpless, divorced from his lay supports.

For the most part, the study healers should be considered as being in a patient's lay referral system. Generally speaking, this position devalued the healer's social position relative to their patients. As discussed in Chapter 13, some of the study healers, especially Mr. Carbonella, occasionally functioned as if they were in a professional referral system. Thus, patients were often referred to Mr. Carbonella by other helping professionals. Most other contact he initiated in a manner similar to that of an intern assigned to a particular hospital ward. Positioning in a patient's professional referral system intrinsically gave Mr. Carbonella more control in his relationship with patients.

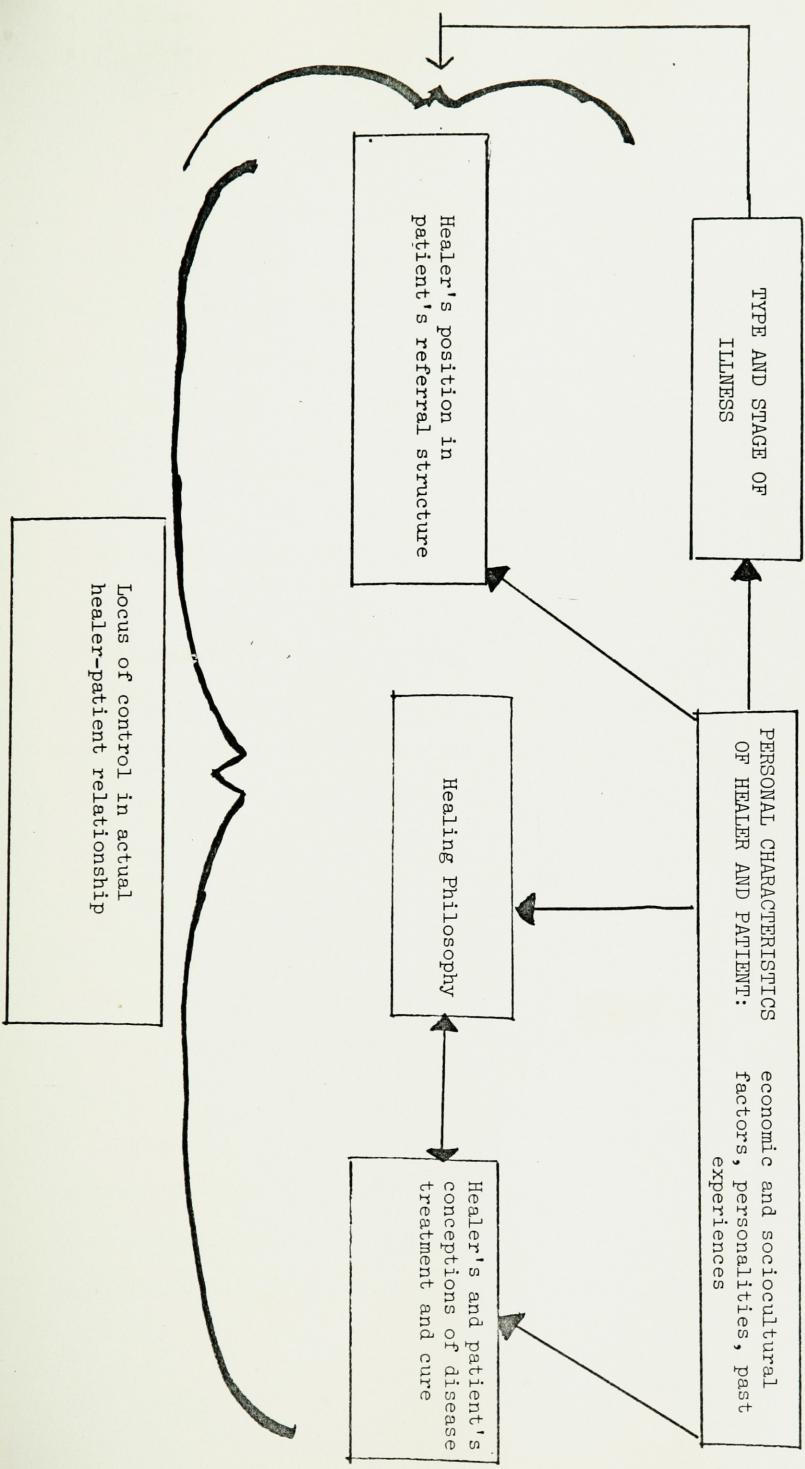
One last important variable which modifies the way in which a healer of a particular philosophy relates to his patients is the social and cultural background of healer and patient. Factors such as age, sex, race, social class and cultural training about how a certain kind of healer and patient should interact, are clearly all relevant to the healer-patient relationship. The study healers, except perhaps for Dr. Lowkap, are different from most orthodox physicians in terms of their social status. Socio-economically, for example, the healers (except Dev Singh and Dr. Lowkap) are in lower social strata than most physicians. Even

Dr. Lowkap has had much more humble beginnings than most physicians. Further, the cultural expectations of a relationship with a healer afford him/her much less authority than a physician. Finally, most of the sample patients using these healers are relatively cosmopolitan middle and upper class patients, who in many cases have more in common socio-culturally with physicians than with the healers. The point is that, generally speaking, the study healers are intrinsically less socially powerful than physicians. Frequently this same discrepancy also occurs with their patients - especially the study patients.

In sum, the locus of power in a healer - patient relationship is the complex result of a number of variables, only some of which have been considered here. Further, because at least some of the modifying variables change over time, eg. an illness, the roles of healer and patient may also change. It might seem that given all of these variables, the healing philosophy is a poor predictor of the actual type of relationship a healer has with a patient. My suggestion is simply that a healer's philosophy of healing serves as a pre-eminent constraint on the form that the relationship takes (See Chart 10B). In the same way that the Platonic ideal of a chair limits what a chair can look like, or a genotype restricts the range of phenotypes, the healing philosophy is proposed as a limiting factor in the type of relationship a healer has with his/her patients.

## FACTORS AFFECTING ACTUAL HEALER-PATIENT RELATIONSHIP

CHART 10 B



Perhaps another analogy will make this putative effect of the healing philosophy even clearer. A culture's belief systems about the process of conception certainly affect, but do not define the procreative relationship. The beliefs constrain the relationship without accounting for all the variance in it. Thus, if two people believe that conception occurs parthogenetically, one might expect the *modal* procreative relationship to emphasize the social role of the woman and de-emphasize that of the man. Likewise, if a doctor and patient believe that the doctor's therapeutic techniques are primarily responsible for the patient's recovery and that only the doctor possesses the skill to use them, one could predict that the doctor would be dominant in a relationship with the patient.

A given healing philosophy, then, can be considered to yield some insight into the *modal* locus of control expected in a patient's relationship with a healer of that philosophy. The significance of this linkage will further unfold in the ensuing chapters..The critical point is that the behavior of a healer affects the behavior of his/her patients. Further, patients' satisfaction with a doctor (healer) has been shown to be largely a function of their expectations. It is possible that patients select healers with the expectation of a certain type of relationship. A theory has been presented which may help explain the healer's behavior, and, as well, predict patient expectations of the healer.

### SECTION III FOONOTES

#### CHAPTER 5

<sup>1</sup>For a variety of perspectives on faith healing, see Carlova (1973), The Christian Science Publishing Society (1966), Kiev (1964), Paulsen (1926), and Zaretzky (1974).

<sup>2</sup>In spite of the fact that Mr. Carbonella chose to hide his identity as a faith healer from most people, the criterion that "at least one other person beyond the healer's circle of friends must concur with the healer's claim to healing" was met by a handful of hospital staff.

<sup>3</sup>Feldman (1966) cited studies that indicate that 32% of the American population were not able to recall even one of these symptoms.

<sup>4</sup>Based on a similar philosophy, a medical team in a burn unit has recently reported an approach to giving patients a maximal role in the decisions regarding their treatment as a means of sustaining hope (Cassell, 1977).

<sup>5</sup>This self-evaluation is remarkably similar to studies reporting the efficacy of faith healing (Frank, 1974).

<sup>6</sup>According to Mr. Carbonella, this number under-represents his usual patient load. The study period was during the summer when he decreases his usual 5-6 hour day to 3-4 hours to allow summer volunteers more opportunities to interact with patients.

<sup>7</sup>None of the 22 patients were seen on more than 1 of the 3 sample days. Hence the number 33 is the number of different patients seen. It is not simply the number of patient encounters.

#### CHAPTER 6

<sup>1</sup>The primary source used is Time Magazine, September 5, 1977. For further information, the reader is referred to the two journals of 3HO, Beads of Truth and the Kundalini Research Institute Journal.

<sup>2</sup>In some ways, the use of Dev Singh's case history as an example of a Perfectionist healer ignores one of the main characteristics of his healing philosophy. As noted, healing in 3HO is in many cases a function of a therapeutic milieu, rather than the relationship between an identifiable healer and patient. Nevertheless, for the purposes of this thesis, a single case history is used. This decision is justifiable on the grounds that Dev Singh is the spiritual leader of his ashram. In that role, he is often identified as a healer. Further, particularly in the healing of non-sect members, individuals in the ashram are singled out as healers.

## CHAPTER 7

<sup>1</sup>For example, Ms. Dolores Krieger, Dean of the New York University School of Nursing has included "Therapeutic Touch" in the standard curriculum of nursing students. Dr. Lawrence Leshan holds regular seminars in which he teaches health professionals how to use aspects of psychic healing in their regular practice (Leshan, 1974)

<sup>2</sup>Effusive with his ideas and beliefs about healing, and welcoming my presence during healing sessions, Mr. Grasso was not as open about his personal life and concerns as the other healers. Consequently, these aspects of his personal profile are sketchy.

<sup>3</sup>Whether women in fact were sent to him I cannot attest. During my observation, however, he did treat a young man who claimed to be a refugee from a cult of witches.

<sup>4</sup>Note that this arrangement of chakras is inconsistent with more accepted versions which place the sacral below the root center. Also, what Grasso has designated as the solar plexus center is more usually called the spleen center. Further, Grasso's use of color only roughly corresponds to more traditional use. For a discussion of the scientific implications of this perspective of a person, see Tiller (1972).

<sup>5</sup>I am not experienced in the observation of trance or hypnotic states and can therefore not provide an educated evaluation of the character of these trances. My impression, however, is that these trance states were fake.

## CHAPTER 8

<sup>1</sup>This review is based on a discussion of homeopathy by Cornacchia (1976). For a good general introduction to homeopathy see Vithoulkas (1975).

<sup>2</sup>Dr. Lowkap stated that the study month was an unusually slow period for him. Chronically exhausted, he was making a concerted effort to shorten his day.

## CHAPTER 9

<sup>1</sup>Dr. Lowkap, (Chapter 8) to whom she was introduced by a mutual friend, travelled to the retreat with her. This common experience served as the foundation on which a professional relationship was to develop.

<sup>2</sup>Unfortunately, the time period chosen (for practical reasons) to survey Ms. Kirbo's patients was unrepresentative of her usual practice. She was in the midst of making plans to leave West Erehwon permanently. Busy with these preparations, she significantly decreased the volume of her practice. Ms. Kirbo did record information about patients who consulted her on one of 3 randomly chosen work days during the study month. From this data and my impressions of her practice during more typical months, the practice description is derived.

<sup>3</sup>Many traditional indigenous healers in the third world are known to base some of their psychological influence on affecting the recovery of a person on their ability to tell the patient what is wrong without the benefit of a history (Frank 1975, Kiev 1964). Indeed it is said that villagers in non-industrialized cultures are often disbelieving in the healing powers of a western trained physician who must resort to asking his/her patients what is bothering them. Their expectation is that s/he should know. (Morley 1973, Paul 1955). I am reminded of the many times that American patients have responded to my inquiries concerning their health, "You tell me! You're the doctor!"

#### CHAPTER 10

<sup>1</sup>This discussion is adapted from Szasz' (1956) review of the doctor-patient relationship. I go further because healers represent a broader range of healing philosophies and conception of disease than do doctors. Note, however, that the three models simplify a greater number of variations in the philosophical relationship of healer and patient.

<sup>2</sup>The theology here is actually more complicated as is pointed out in Chapter 5.

### SECTION III

#### REFERENCES

##### Chapter 5

Cassel EJ: Autonomy and ethics in action. NEJM 297: 333-334, 1977

Carlova J: Even M.D.'s have faith in this faith healer. Medical Economics, 98-101, Sept. 1973

A Century of Christian Science Healing. Boston, Massachusetts , The Christian Science Publishing Society, 1966

Feldman JJ: The Dissemination of Health Information. Chicago, Aldine Publishing Company, 1966

Frank JD: Persuasion and Healing, Revised Edition. New York, Schocken Book, 1975

JAMA 195: 292, 1956

Kasl SV and Cobb S: Health behavior, illness behavior, and sick role behavior. II. Sick-role behavior. Archives of Environmental Health 12: 531-541, 1966

Kiev A, ed: Magic,Faith, and Healing. New York, Macmillan, 1964

Paulsen AE: Religious healing, JAMA 80: 1519-1524, 1617-1623, 1692-1697, 1926

Zaretzky II and Leone MP, Editors: Religious Movements in Contemporary America. Princeton, Princeton University Press, 415-455, 1974

##### Chapter 6

Basham AL: Hinduism, The Concise Encyclopedia of Living Faiths. Edited by RC Zaehner, Boston, Beacon Press, 225-260, 1959

Yogi Bhajan's synthetic Sikhism. Time Magazine, September 5, 1977

##### Chapter 7

Grad B, Cadoret J, and Paul GI: An unorthodox method of treatment of wound healing in mice. Internal J Parapsych 3: 5-24, 1961

\_\_\_\_\_ : Some biological effects of the "Laying-on-of-hands": A review of experiments with animals and plants. J Amer Soc Psychical Research 59: 95-127, 1965

\_\_\_\_\_ : Healing by the Laying-on-of-Hands: Review of experiments and implications. Pastoral Psychology 21: 19-26, 1970

LeShan L: The medium, the Mystic, and the Physicist. New York, Ballantine Books, 1974

                  : Alternate Realities. New York, M Evans and Company, Inc, 1976

Tiller WA: Consciousness, radiation, and the developing sensory system, The Dimensions of Healing-- A symposium. Los Altos, California, The Academy of Parapsychology and Medicine, 61-85, 1972

### Chapter 8

Cornacchia HJ: Consumer Health. Saint Louis, The CV Mosby Company, 1976

Dubos R: A God within. New York, Charles Scribner's Sons, 1972

Vithoulkas G: Homeopathy-- Medicine of the New Man. New York, Avon Books, 1975

### Chapter 9

Davis N: The Curse Causeless Shall Not Come. Topton, North Carolina, Nord Davis, Jr., 1976

Frank J: Persuasion and Healing, Revised Edition. New York, Schocken Books, 1975

Kiev A, ed: Magic, Faith, and Healing. New York, Macmillan, 1964

Kirban S: Health Guide for Survival. Huntington Valley, Pennsylvania, Salem Kirban, Inc., 1976

Morley D: Paediatric Priorities in the Developing World. London, Butterworth & Co. (Publishers) Ltd., 1973

Paul DB: Health, Culture and Community. New York, Sage Foundation, 1955

## Chapter 10

Fabrega H: Disease and Social Behavior. Cambridge, Massachusetts, the MIT Press, 1974

\_\_\_\_ and Silver DB: Illness and Shamanistic Curing in Zinacantan. Stanford, California, Stanford University Press, 1973

\_\_\_\_ and Van Egeren L: A behavioral framework for the study of human disease. Ann Int Med 84: 200-208, 1976

Francis V Korsch BM and Morris MJ: Gaps in doctor-patient communication. NEJM 280: 535-540, 1969

Freidson E: Client control and medical practice, Patients, Physicians and Illness, Second Edition. Edited by E Jaco, New York, The Free Press, 214-221, 1972

Korsch BM, Gozzi EK and Francis V: Gaps in doctor-patient communication. I. Doctor-patient interaction and patient satisfaction. Peds 42: 855-871, 1968

Long H: The Power Within Us. New York, Duell, Sloan and Pearce, 1951.

McKinlay JB: Some approaches and problems in the study of the use of services - an overview. J Hlth Soc Behav 13: 115-152, 1972

Szasz TS and Hollender MH: A contribution to the philosophy of medicine - the basic models of the doctor-patient relationship. Arch Int Med 97: 585-592, 1956

SECTION IV

THE PATIENTS

CHAPTER 11

THE PATIENTS

## OVERVIEW

This chapter presents the results of the patient interviews. The data has been organized so as to reflect many of the key variables that heretofore have been considered important in the explanation of illness behavior (Chapter 2). First, the patients are identified in terms of a number of personal attributes, e.g. socio-demographic characteristics, medical diagnosis, and medical knowledge. Patients' sources of care for their present illnesses are also indicated. Each patient is assigned an identification number which is keyed to his/her primary healer's identification Roman Numeral. Next, the patient data is reviewed with respect to less easily concretized reasons for patients' choice of unorthodox care. Six broad categories of information about the patients are examined in this search: past illness experiences and behavior, medical skepticism, social contexts, illness and healing beliefs, aspects of the healer-patient interaction, and aspects of the present illness experience. Throughout the discussion, many of the themes raised in the HEALERS section re-emerge.

## PATIENT IDENTIFICATION

To begin, data descriptive of certain social and medical attributes of 25 unorthodox patients are presented. The data describe a group of people remarkably different from the kind of people identified in the literature as using unorthodox

health care (cf. p. 14). Throughout the next chapters, various points will be made by using quotations from patient interviews. This introductory data is used not only to describe a sample of patients, but also to provide a brief summary of key personal characteristics of 25 individuals. Accordingly, in the text, the data is grouped to provide an overall impression of the sample. The tables are designed to serve as a convenient reference in placing quotations in the context of a given individual.

#### Demographic Information

Demographic information is presented in Tables 11 A, B. Note that virtually all age groups are represented: 2 children (less than 13 years), 3 adolescents (13-21 years), 8 young adults (22-39), 9 middle aged adults (40-59 years), and 3 elderly adults (greater than 59 years). (In my experiences, unorthodox care for very young children, less than 5 years, is unusual. In the sample, 9 patients were male and 16 were female. Twenty (20) of the patients (all over 26 years old) had been married. Of these people: 2 were in their second marriage, 1 was in her third marriage, 2 were now divorced, and 1 more was separated. All patients were white. All but 5 patients' families have lived in the United States for at least 3 generations. Three (3) patients were the first generation of their families to live in the United States. Eleven (11) patients satisfied the criteria of social class I. Four (4)

TABLE 11A  
SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PATIENT SAMPLE

PATIENT NUMBER <sup>a</sup>	AGE	SEX <sup>b</sup>	MARITAL STATUS <sup>c</sup>	SOCIAL CLASS
I A	50	F	M	I
B	63	M	M	I
C	34	F	M	III
D	38	F	D	II
E	40	F	M	III
III A	25	F	NM	II
B	28	F	SEP	I
C	57	M	M	I
D	26	M	NM	III
E	37	F	M	I
IV A	8	M	NM	III
B	17	F	NM	III
C	52	M	M	II
D	50	F	M3	III
E	28	F	D	II
V A	27	M	M	I
B	9	M	M	I
C	73	F	M	III
D	58	F	M	I
E	15	M	NM	III
VII A	50	F	M	I
B	67	M	M	III
C	57	F	NM	I
D	21	F	M2	I
E	44	F	M2	III

<sup>a</sup>The identification is composed of the healer's number and a letter for each patient.

<sup>b</sup>"F" refers to female. "M" refers to male.

<sup>c</sup>"M" refers to a person currently in his/her first marriage. "M" followed by a number indicates the number of the marriage the person is currently in, eg. M2 refers to the person's second marriage. "NM" means never married. "SEP" means separated. "D" means divorced.

patients were in class II. The remaining 10 were in class III.

Table 11B shows all three major religious denominations are represented in the sample. Catholicism is the background of about half of the patients (12 plus 1 patient who is now Sikh, but was raised as a Catholic). Four (4) patients were Jewish (1 Sikh was at one time a practicing Jew). Six (6) patients were Protestant. The remaining 3 patients were Sikhs.

More than one third of the patients lived outside the Greater Erehwon area. One (1) of these people lived outside of Connecticut. The distance of many of the patients' residences from their healer's place of practice reflects the unorthodox patients' geographic mobility in seeking care. The limitations imposed by my inability to interview patients who lived at yet greater distances from Erehwon may have underemphasized the mobility of the patients. As noted in chapters 8 and 9, patients tended to travel the furthest to see Richard Lowkap (V) and Bette Kirbo (VII).

Except for 2 people, all patients had some form of health insurance. These 2 patients (of Healer III) were members of ZHO (cf. p.112), which would cover their expenses in the event of a medical catastrophe.

#### Medical Sophistication

I collected information in five areas to obtain a rough measure of a person's medical sophistication: (1) close family relation to, or identity as, an orthodox health professional,

TABLE 11B  
SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PATIENT SAMPLE

PATIENT NUMBER	RELIGIOUS AFFILIATION	RESIDENCE	HEALTH INSURANCE
I A	Jewish	out state	H, OP
	Protestant	out	PPHP
	Protestant	Mammoth Park	H, OP
	Protestant	North Erehwon	H, OP
	Catholic	out	H, OP
III A	Protestant	New Erehwon	H, OP
	Sikh	New Erehwon	H, OP
	Catholic	out	H, OP
	Sikh	New Erehwon	None
	Protestant	New Erehwon	PPHP
IV A	Catholic	out	H
	Catholic	North Erehwon	Unknown
	Catholic	Mammoth Park	H, OP
	Catholic	North Erehwon	H, OP
	Protestant	New Erehwon	PPHP
V A	Sikh	New Erehwon	None
	Catholic	New Erehwon	H, OP
	Jewish	West Erehwon	H, OP
	Catholic	out	None
	Jewish	out	H, OP
VII A	Catholic	Mammoth Park	H, OP
	Catholic	out	H, OP
	Jewish	out	H, OP
	Catholic	out	H, OP
	Catholic	out	H, OP

a"out" means that the person lives outside of Greater Erehwon.

"out state" means that the person lives outside of Connecticut.

b"H" means the patient has at least some coverage for hospitalization.

"OP" means the patient carries insurance which covers at least some out-patient expenses. "PPHP" means the patient belongs to a pre-paid health plan.

(2) primary written source of medical information, (3) the person's knowledge of the 7 warning signs of cancer (American Cancer Society), (4) his/her knowledge of the signs and symptoms of diabetes mellitus and myocardial infarction, and (5) his/her awareness of the medical aspects of his/her own problem. In each of the last three areas, a person was judged according to the medical knowledgeability criteria discussed in Appendix H. Judgments made in areas 4 and 5 are simply meant to convey my subjective impression of the relative medical sophistication of the patients. The judgements in area 3 are comparable to national data.

Referring to Table 11C, note that 10 patients are either themselves, or are closely related to, an orthodox health professional. Note also that 10 patients report that they regularly use orthodox medical books, eg. Merk's Manual, Harrison's Principles of Internal Medicine, as a primary written source of medical information. Ten (10) patients are Very Knowledgeable about cancer. Ten (10) patients are Knowledgeable and 5 patients are Unknowledgeable in this area. Nine (9) patients are Very Knowledgeable in the area of Diabetes and Myocardial Infarction. Seven (7) are Knowledgeable and 9 are Unknowledgeable in this area. Ten (10) patients are Very Knowledgeable, 5 are Knowledgeable and 10 are Unknowledgeable about their own medical problem.

TABLE 11C  
MEDICAL SOPHISTICATION

Patient Number	Related to or [Identity] as Health Professional <sup>a</sup>	Use of orthodox medical textbooks	KNOWLEDGE		
			CA <sup>b</sup>	DM/MI <sup>c</sup>	PI <sup>d</sup>
I A	Registered Nurse	yes	VK	VK	VK
B			K	UK	UK
C			VK	K	K
D			K	VK	K
E			K	K	UK
III A	Occupational therapist		K	K	K
B			K	UK	UK
C			UK	UK	UK
D			K	UK	UK
E			VK	K	VK
IV A	Medical Doctor	yes	K	VK	VK
B			K	VK	VK
C			UK	UK	UK
D			VK	K	K
E			UK	UK	UK
V A	Hospital Board Member [Registered Nurse] [Nutritionist] Pharmacist	yes	UK	UK	UK
B			VK	VK	VK
C			VK	VK	VK
D			K	UK	K
E			VK	K	VK
VII A	dentist physical therapist	yes	VK	VK	VK
B			K	K	K
C			VK	VK	VK
D			UK	UK	UK
E			VK	VK	VK

<sup>a</sup>The squaring of an entry means that the patient is the health professional. A non-square entry means that the patient has a close relative who is the indicated health professional.

<sup>b</sup>CA = Cancer

<sup>c</sup>DM/MI = Diabetes Mellitus and Myocardial Infarction

<sup>d</sup>PI = Present Illness

### Medical Diagnosis

The medical diagnoses of the 25 patients are presented in Table 11D. The diagnoses reflect the patients' recall of what medical doctors told them was wrong.<sup>1</sup> For the time being, they are used only as an aid in describing the patients. Later, the patients' illnesses will be considered in more depth (Illness Experience, p. 278).

The medical problems presented to the healers by these 25 patients run the gamut from minor self-limited disease, e.g. upper respiratory infection (VI<sup>d</sup>), to common chronic disease, e.g. rheumatoid arthritis (VII<sup>c</sup>), to formidable malignancies, e.g. gastric cancer, and to exceedingly rare problems like ectopic atypical pinealoma (IV<sup>a</sup>). The spectrum is heavily weighted toward chronic disease. Fifteen (15) patients were suffering with chronic problems-- some of which were in a stage of acute exacerbation. Only 6 of the patients had an acute problem. Four (4) persons had a malignancy.

### Summary

Various identifying characteristics of 25 unorthodox patients have been presented. Demographically, the sample is remarkably different from those patients usually considered utilizers of unorthodox healers. Excepting the very young, the full spectrum of age groups is represented. In addition, virtually none of the patients are burdened by the kind of financial, language, transportation or social characteristics that many

TABLE 11D

## MEDICAL DIAGNOSES OF SAMPLE PATIENTS

PATIENT NUMBER	MEDICAL DIAGNOSIS
I A	Herniated discs, vertebral collapse
B	Renal colic
C	Herniated discs
D	Persistent vomiting and weight loss
E	compound fracture of tibia and fibula, osteomyelitis
III A	Broken nose, facial lacerations
B	Scoliosis, recurrent abdominal pain
C	Leukemia
D	Infected dyshidrotic eczema
E	Discoid lupus erythematosis
IV A	Ectopic atypical pinealoma
B	Bronchitis, asthma
C	Parkinson's disease
D	Labrynthitis
E	Granulomatous colitis
V A	"Stiffneck," sleep disturbance
B	Poison ivy
C	Hypertension
D	Upper respiratory infection
E	Recurrent pharyngitis, allergies
VII A	Cervical cancer
B	Gastric cancer
C	Ulcerative colitis
D	Dysmenorrhea, menstrual irregularity
E	Rheumatoid arthritis, psoriasis

investigators have suggested lead people to alternative forms of healing<sup>2</sup> (p. 14). Relative to the national population, most of the sample is medically informed about cancer (cf. Appendix H). More than a third of the patients are closely related to, or are themselves, orthodox health professionals. Likewise, more than a third read orthodox medical textbooks. The range of medical problems presented to the healers reflects the full spectrum of pathophysiology that a physician might encounter. The range is unusual, however, for including two rare diseases in a small sample.

#### SOURCE OF CARE FOR PRESENT ILLNESS

Before probing the patients' case histories for the rationale behind their unorthodox behavior, certain aspects of this behavior are presented. Of primary interest is the source of care for the present illness.

Note in Table 11E, that virtually all (22) of the patients' first contact with a health provider was with an orthodox physician. Of the 22, however, 3 people used a physician only for the initial diagnosis or the subsequent monitoring of the disease. The remaining 19 had received some form of orthodox therapy before seeking unorthodox care. Only 3 patients first resorted to a healer for their present illness.

Fifteen (15) patients are now using only a healer for their present illness. (They may use an orthodox physician for

SOURCE OF CARE FOR PRESENT ILLNESS

Patient Number	Orthodox MD as First Contact	Healer as First Contact	Orthodox MD for Medical Diagnosis and Following of Disease Only (No therapy)	Concurrent Use of Healer and MD	Current Use of Healer(s) only
I A	X			X	X
I B	X			X	X
I C	X			X	X
I D	X			X	X
I E	X			X	X
III A	X				
III B	X				
III C	X				
III D	X				
III E	X				
VI A	X		X		
VI B	X		X		
VI C	X		X		
VI D	X		X		
VI E	X		X		
V A	X			X	X
V B	X			X	X
V C	X			X	X
V D	X			X	X
V E	X			X	X
VII A	X			X	X
VII B	X			X	X
VII C	X			X	X
VII D	X			X	X
VII E	X			X	X
Totals	19	3	3	10	15

another reason.) Ten (10) patients, however, continue to use a medical doctor concurrently with a healer.

Originally, all patients have been identified as patients of a particular healer (Table 11A). Table 11E documents that most patients have used both orthodox and unorthodox care. Table 11F shows that several patients have used more than one healer for their current problem. Eleven patients have used healers (excepting their physician) from multiple philosophical categories, eg. healing categories VII, V and IV.

#### Implications for the Investigation

A series of decisions to seek health care were made by these patients. After the first contact with a health practitioner, other behavioral choices were made. A decision to consult one healer does not necessarily exclude the possibility of concurrently using other healers either within or beyond the same philosophic category of healing. The patient's decision to seek a particular healer must then be studied as part of a process, rather than as an isolated event.

#### THE CHOICE OF UNORTHODOX HEALTH CARE

The remainder of this chapter will address those factors identified in the patient data as associated with the choice of unorthodox health care. Table 11G shows that these factors can be broken into 6 categories: past illness experiences

TABLE 11F

## TYPES OF UNORTHODOX CARE USED FOR PRESENT ILLNESS

Patient Number	Philosophical Types	Techniques
I A	I,VII	Faith healing, chiropractic
B	I	Faith healing
C	I,VII	Faith healing, chiropractic
D	I	Faith healing
E	I	Faith healing
III A	III	3HO Ashram
B	III,V,VII	3HO Ashram, homeopathy, chiropractic
C	III	3HO Ashram
D	III,V	3HO Ashram, homeopathy
E	I,III,III,IV,V,VI,VII	Multiple techniques in each category
IV A	IV	Psychic healing
B	IV	Psychic healing
C	IV	Psychic healing
D	IV	Psychic healing
E	IV	Psychic healing
V A	III,V,VII	Multiple techniques in each category
B	V	Homeopathy
C	V	Homeopathy
D	V	Homeopathy
E	V,VII	Homeopathy, chiropractic
VII A	I,IV,V,VI,VII	Multiple techniques in each category
B	VII	Reams and Laetrile
C	V,VII	Homeopathy, naturopathy, Reams
D	IV,VII	Psychic healing, hypnosis, Reams
E	IV,V,VII	Psychic healing, yoga, health food store, Reams

FACTORS ASSOCIATED WITH THE CHOICE OF UNORTHODOX CARE

TABLE 11G

Patient Number	Past Illness Experiences and Behavior			Medical Orientation	Social Context
	Remarkable Past Medical History	Dissatisfied With Recent Medical care	Positive Past Experience with Healers		
I A	X	X	X	Anti-Medicine	Support and/or Referral
	X	X	X		
	C				
	D				
	E				
III A	X	X	X	X	X
	B				
	C				
	D				
	E				
IV A		X	X	X	X
	B				
	C				
	D				
	E				
V A	X	X	X	X	X
	B				
	C				
	D				
	E				
VII A	X	X	X	X	X
	B				
	C				
	D				
	E				
Totals	9	16	14	7	18

<sup>a</sup>For socio-demographic factors see Tables 11A, B, and text. For aspects of present illness experience See Table 11 L.

TABLE 11C (Continued)  
FACTORS ASSOCIATED WITH THE CHOICE OF UNORTHODOX CARE

ILLNESS AND HEALING BELIEFS					HEALER-PATIENT RELATIONSHIP			
Patient Number	Patients and Healers Healing Philosophies Congruent	Seeking Benefits of Unorthodox Techniques	Avoiding Risks of Orthodox Techniques	Seeking Personal Qualities of Healer or Doctor	Bothered by Personal Qualities of Doctors	Seeking Better Physiologic Explanations of Illness <sup>c</sup>	Seeking Meta-Physical Explanations of Illness	
I A	X	X	X	X	X	X	X	X
	B	X	X	X	X	X	X	X
	C	X	X	X	X	X	X	X
	D	X	X	X	X	X	X	X
	E	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X
III A	X	X	X	X	X	X	X	X
	B	X	X	X	X	X	X	X
	C	X	X	X	X	X	X	X
	D	X	X	X	X	X	X	X
	E	X	X	X	X	X	X	X
IV A	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X	X
	B	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X
	C	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X
	D	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X
	E	X	X <sup>b</sup>	X <sup>b</sup>	X	X	X	X
V A	X	X	X	X	X	X	X	X
	B	X	X	X	X	X	X	X
	C	X	X	X	X	X	X	X
	D	X	X	X	X	X	X	X
	E	X	X	X	X	X	X	X
VII A	X	X	X <sup>b</sup>	X	X	X	X	X
	B	X	X <sup>b</sup>	X	X	X	X	X
	C	X	X	X	X	X	X	X
	D	X	X	X	X	X	X	X
	E	X	X	X	X	X	X	X
Total	21	20	11	13	11	2	8	14

<sup>b</sup>These patients were desparate, i.e. they exhausted all orthodox methods without relief.  
<sup>c</sup>These patients wanted to avoid all physiologic explanations, cf. text.  
 dIII, IV<sup>b</sup>, and VII<sup>a,c</sup>, assumed an active role, cf. footnote 7.  
 ePatient's mother (IVa) or wife (IVc) acted on behalf of patient.

and behavior, medical skepticism, a patient's social context, illness and healing beliefs, aspects of the healer-patient interaction, and aspects of the present illness experience. Because the main function of this study is to generate ideas, rather than to test hypotheses, data for the entire patient sample is not presented for each of these categories. Instead, selected information is used to exemplify the rationale for suggesting a particular variable as relevant to the choice of unorthodox care.

#### Past Medical Experiences and Behavior

##### Past Medical History

Besides their current medical problems, 9 of the 25 patients reported remarkable past medical histories. These 9 people (Table 11G) have all had long difficult searches for health. The frustrations of this struggle have contributed to their decision to seek in an unorthodox healer what their regular medical doctor could not provide for them. One possibility, others regarding past medical experiences are brought up later, is that these patients have sought someone who also has suffered-- someone who can, by example, show them how to rise from the despair of continued defeat. A characteristic that all of the five healers shared is either remarkable past medical histories or particularly stressful lives. Healers I, III, and V have been most successful in finding health in what continues to be difficult times for them. They might be expected to be

particularly well adapted to helping the patients with a remarkable past medical history.

An excerpt from patient Ia's case is illustrative.

Patient Ia says that she has been living in a "pain capsule" since a neck injury 31 years ago.

I've been sick since I was 19. I hated my body. People kept telling me to go into psychotherapy. I just couldn't believe that they couldn't find anything wrong with me.... It used to be that whenever I turned my neck I used to get tremendous shooting pains throughout my body.

Finally, medical doctors did find a physical basis for her excruciating pains. Surgery successfully eliminated the pain, but not the illness. Recuperating, she was on the verge of suicide when she asked Mr. Carbonella (who she had met during previous hospitalizations) to visit her. One reason for this request was because of the healing example he has provided for her.

When Joe came to me and told me about his problems, I said, 'My God! Why am I crying...? I believe in Joe as a person-- touching people, caring for people.... Rain or shine. He comes here with all of his problems. Maybe he was given a bad back so that he could do these things for people.... Before Joe, I don't think I wanted to go back out and face the world.

Patient VIIa now has cervical cancer. She is using more than one unorthodox healer. She recently chose to consult, in tandem with a Healer VII, an unorthodox medical doctor who allegedly cured himself of a colonic cancer using an unorthodox nutritional regimen.

Patient Ic had several herniated discs. She attributes her speedy recovery to her contact with Mr. Carbonella, who had

had similar experiences.

It wasn't until after the fusion that I figured I wasn't all that bad. Before the operation, I kept telling myself that I must be terribly weak. I had friends who had back pain, but they didn't complain so much that they got an operation. After the fusion, Joe would come in and tell me how, when he had his operation, he would break down and cry. I'd look at him and see how strong he was, and what he was able to do for people. I said, well if he was in pain, it must be bad. Maybe I'm not so bad after all.... I no longer looked at my condition as a punishment.... If it hadn't been for Joe, the depression I was under would have lasted much longer. I would have backslid and not had the energy to push myself to do the exercises so I could get out as early as I did.

#### Satisfaction with Past Medical Interactions

Virtually all of the respondents conjured up a few negative comments about isolated orthodox practitioners. Surprisingly, 9 of the patients felt that, overall, past medical interactions were satisfying. The remainder of the sample (16) was to varying degrees dissatisfied, in particular with the most recent medical experience (Table 11G). Dissatisfactions fell within 2 broad groups: perceived objectionable characteristics or deficiencies of either the healer-patient interaction, or of the diagnostic and treatment process. In the first category, patients focussed on personal qualities of the provider or on the distribution of power within the relationship. The second type of dissatisfactions consisted of issues of treatment efficacy, risk of treatments, range of treatments available, and difference in philosophies of illness and healing.

All of these issues will be detailed in other contexts.

The point here is only to examine how past medical experiences have influenced present behavioral choices. Significantly, not all patients have had negative experiences. For them still other factors must be operating to prompt their choice of unorthodox care.

#### Past Experiences with Unorthodox Healers

Over half of the patient group (14) had resorted to unorthodox health care for other problems (Table 11H). Two (2) of these patients were dissatisfied with some of these unorthodox experiences and sought yet different unorthodox healers. These 14 patients specifically cited positive past experience with either their current healer or others, as among the main reasons for their unorthodox illness behavior. The positive unorthodox experiences can be grouped in the same fashion as the negative orthodox experiences listed above, and will be discussed under the appropriate headings below.

The group of patients dissatisfied with orthodox care overlaps with the group which had positive past experiences with unorthodox healers. There are 4 patients (Id,e, IIIc and IVb) who fall in neither group. Patients Id and e did not actually seek unorthodox care. As noted in Chapter 5, Mr. Carbonella initiates contact with his patients. (He had done so with patients Ia, b and c during previous hospitalizations. They had requested that he help them on this most recent admission.) Patient IVb sought care from Mr. Grasso primarily because of

TABLE 11H  
TYPES OF UNORTHODOX CARE USED FOR PAST ILLNESSES

Patient Number	Philosophical Types	Techniques
I A B C D E	I I I none none	faith healing faith healing faith healing none none
III A B C D E	III III,V,VII none III,V,VII VII	3HO ashram 3HO ashram, homeopathy, chiropractic none 3HO ashram, homeopathy, naturopathy chiropractic, unorthodox MD chiropractic, bioenergetics
IV A B C D E	VII none none none none	none none none psychic healing, homeopathy, chiropractic none
V A B C D E	III,V,VII V,VII V V,VII V,VII	3HO ashram, homeopathy, naturopathy, multiple technical healers homeopathy, Reams homeopathy homeopathy, naturopathy, hypnosis, Reams homeopathy, chiropractic
VII A B C D E	I,IV,V,VI,VII none none none none	multiple techniques in each category none none none none

healing beliefs and expectations about the healer-patient interaction. For patient IIIc, a man with leukemia, denial of his disease was a main ingredient of his choice for unorthodox care.

#### Medical Orientation

People's medical skepticism was assessed using a combination of objective and subjective criteria (cf. Appendix I). On the basis of these criteria, patients were classified in three groups, pro-medicine, neutral, and anti-medicine.<sup>3</sup> These categories are meant to reflect a person's general medical orientation, rather than their satisfaction with particular physicians-- though clearly medical orientation and past medical experiences overlap (Suchman 1965).

Table 11I presents people's attitudes toward orthodox medicine. Not surprisingly, all 5 patients of Joe Carbonella, who were in the hospital, were pro-medicine. In all, 12 patients were positive in their attitude toward medicine; 6 were neutral, and 7 were anti-medicine. Only these last 7 patients stated that one of their reasons for seeking unorthodox care was because they specifically were opposed to medical diagnostic and treatment procedures (Table 11G).

#### Regular Source of Care

Consistent with the generally positive attitudes toward medicine, 15 patients stated that their regular primary

TABLE III  
MEDICAL ORIENTATION

PATIENT NUMBER	MEDICAL ORIENTATION
I A	pro-medicine
B	pro-medicine
C	pro-medicine
D	pro-medicine
E	pro-medicine
III A	pro-medicine
B	so-so
C	pro-medicine
D	anti-medicine
E	
IV A	pro-medicine
B	pro-medicine
C	so-so
D	so-so
E	pro-medicine
V A	anti-medicine
B	anti-medicine
C	pro-medicine
D	anti-medicine
E	anti-medicine
VII A	anti-medicine
B	so-so
C	so-so
D	so-so
E	anti-medicine

source of medical care was an orthodox physician (Table 11J). Two of these patients (IVc and b) stated, however, that the main reason they maintained an orthodox medical doctor as their primary health practitioner is for the eventuality that they were hospitalized, or in case their healer was not available. Patient IVc says, "I still need a doctor in case Lenny (healer IV) can't come. I also need one in case I go to the hospital. I can't tell them my doctor is a psychic healer."

One (1) patient desired, but did not currently have a primary physician. One (1) patient had no regular source of care. Six (6) patients used their healers for primary care. Two (2) more patients used a different healer for primary care from the one they were consulting for current problems.

The relative paucity of anti-medical viewpoints also is consistent with the behavioral data presented concerning the actions taken for the present illness (p. 230). Virtually all patients were sufficiently appreciative of scientific medicine to at least initiate the professional helping process with an orthodox physician.

#### The Social Context

Health practitioners are not the only persons consulted by a person seeking help. Before and after utilizing health services, people, to varying degrees, generally consult their relatives and friends. As described on p.20 , this process of consulting lay persons was called the lay referral system by

TABLE 11J  
REGULAR SOURCE OF PRIMARY HEALTH CARE

PATIENT NUMBER	REGULAR SOURCE OF CARE
I A	MD
B	MD
C	MD
D	MD
C	MD
III A	none
B	3HO Ashram
C	MD
D	3HO Ashram
E	MD
IV A	MD
B	MD
C	MD
D	MD
E	none
V A	Homeopath
B	Homeopath
C	Homeopath
D	MD
E	Homeopath
VII A	Unorthodox MD
B	Chiropractor
C	MD
D	MD
E	MD

Freidson (1960)<sup>4</sup>, Kasl (1974) made a point of distinguishing the lay referral system as it influences the decision-making process from social support as it facilitates an action intended by a person. This section takes a closer look at the relevance of these aspects of peoples' broad socio-cultural context, as well as their more immediate social context.

#### Quackery and the Broader Social Group

Socio-culturally, the sample patients are probably deviant from their broader social group, i.e. mainstream classes I, II, and III, in their choice of health care. (This is an assumption that has yet to be adequately tested.) Quackery is a derogatory social term used by organized medicine to describe the unscientific practices of the unorthodox healer. Undoubtedly, most medical doctors and many of the sample patients' larger socio-cultural group would probably use this term to describe the activities of the subject healers. The sample patients either expected, or actually received the opprobrium of their orthodox physician and larger social group for using alternative healers.

Earlier, (p.232), it was noted that 10 of the sample patients use a medical doctor concurrently with a healer. All but 2 of these 10 patients, however, concealed their unorthodox activities from their physicians. The common complaint was that physicians were too "narrow-minded" and "egotistic" to accept their patients use of alternative healing arts. One patient (VIIc) informed her physician of her un-

orthodox activities after hospitalization. She had suffered the acute onset of chills and weakness after beginning her Reams diet. "I told the surgeon when I was in the hospital that I had been on Reams. He said, 'You're intelligent. Don't let them take your money.'"

Generally, the sample patients expected the disapproval of their larger socio-cultural group, i.e. fellow workers, school mates etc. For this reason the patients usually concealed their unorthodox activities from this larger group. One patient did not. Patient IVb says that "Alot of people laugh at you when you talk about it (psychic healing). You lose friends quick. But I've gained a new set of friends quick." IVb's larger social group, i.e. her school peers, were hostile to her unorthodox behavior, but her most immediate referent group, i.e. her mother and grandfather, were firm believers in psychic phenomena and were supportive while IVb was gaining a broader group of friends sympathetic to her actions.

#### Quackery and Immediate Social Group

More narrowly, the immediate referent group (family and friends) are, in various ways supportive of 18 of the 25 patients' unorthodox illness behavior (Table 11K).<sup>5</sup> For many of the patients, it was a friend or relative who referred them to a particular healer.

For example, Patient IVd says that, "Since I was a little girl, the whole family believed in psychic phenomena. I always

TABLE 11K  
ROLE OF IMMEDIATE SOCIAL GROUP IN DECISION  
TO SEEK UNORTHODOX CARE

PATIENT NUMBER	ROLE OF SOCIAL GROUP IN DECISION <sup>a</sup>
I A	no role
B	no role
C	no role
D	no role
E	no role
III A	supported and referred
B	supported and referred
C	supported and referred
D	supported and referred
E	supported
IV A	skeptical
B	supported
C	supported and referred
D	supported
E	supported and referred
V A	supported and referred
B	supported and referred
C	supported
D	supported and referred
E	supported and referred
VII A	supported (and discouraged) <sup>b</sup>
B	supported and referred
C	supported and referred
D	supported and referred
E	skeptical

<sup>a</sup>Supported means that the patient's immediate social group supported his/her decision to seek unorthodox care. Referred means that a member of the social group encouraged the patient to use a particular healer. No role means that the social group had no influence before or after the decision. Skeptical means that the patient's significant others doubted the wisdom of the patient's decision.

<sup>b</sup>Patient VII A's husband originally discouraged her from seeking unorthodox care. Her family however was supportive cf. text.

used to tell fortunes by cards." Patient VIIa's grandfather was an unorthodox medical doctor who invented a machine that VIIa says he "used to cure hundreds of people from cancer." VIIa refused operation for her current illness (cervical cancer) because of beliefs instilled by her grandparents.

I didn't want to be cut since I found in my mother's papers that in 1961 when I had shooting pains in the abdomen that I had had evidence of cancer of the pancreas and gallbladder duct. I was given electric treatments (with the above-named machine) by my grandfather. My grandfather used to say that cutting cancer would spread it.

Patient VIIb illustrates how a social group can both influence and support a patient's choice of unorthodox care.

As soon as you have cancer, you talk about it to everyone. When people find out you have cancer, everyone is sending you information. In the past 4-5 years, many people in my extended family have died of cancer. I have some neighbors who have died of cancer too. They all received orthodox treatment. I've noticed that a lot of them seem to do much worse after their surgery. It seems to do them in. And they all die such painful deaths.

When he was diagnosed as having gastric cancer, his whole family not only supported, but also encouraged his choice of unorthodox care. Indeed, he was referred to Ms. Kirbo by a close friend. Another friend who had made the pilgrimage to Mexico to buy Laetrile, died before he used it. The entire \$2,000 supply was given to VIIb by the man's family.

Although the sample patients recognized and often concealed their utilization behavior from their larger social group, they did not themselves consider their healers as

quacks. The sample patients did not define quacks as people who practiced medicine using unconventional or scientifically unjustified techniques. Rather, most of the patients made their judgments on the basis of the personal qualities of the healer. The most common way that the patients characterized a quack was on the basis of his/her sincerity and/or attitude toward money.

Patient VIIc, after her surgeon had warned her about the futility of her unorthodox practices (see above), thought again about what to do.

I wasn't sure at first. I couldn't come back at them (her attending physicians), because I didn't know enough. But then I thought about it and wondered if they (Ms. Kirbo and assistants) were out for my money. I gave her the \$30 check and she left it there as if it didn't matter and she was so nice and sincere.

If a healer believes in what s/he is doing, s/he is usually not regarded as a quack. Patient Ic said,

I've gone to chiropractors and osteopaths and gotten relief. I have told this to my orthopedist who said, 'You shouldn't go to those quacks.' If a person believes in what they are doing then they're not a quack. Some people might call a faith healer a quack. I don't know what they'd call Joe (healer I), but he gave me something I needed. It's not important what you call it. If Joe wants to call it faith healing and that's what he believes-- that's what matters. Even sincere people who are misdirected have some beneficial effect just by giving people faith in something. Joe gave me a tremendous amount just by showing me that there was at least one thing I wasn't inferior in. That was enough to turn my whole attitude around. Anyone who can do that does not deserve to have the title quack thrown at him.

Patient IVd said that "Quacks are very egotistic. They believe that they are doing it (the healing) themselves."<sup>6</sup>

Several patients were willing to consider medical doctors

as quacks. Patient Va says, "I think alot of doctors are quacks because they have their set route and won't deviate from it. They also are people who don't practice what they preach. If you're not ready to learn and see each patient as a unique individual (you are a quack)."

### Illness and Healing Beliefs

As noted in Chapter 2, virtually all models of health/illness behavior consider a person's health related beliefs as critical variables in determining his/her decision to seek health care. They were among the central areas of concentration of the data collection. Indeed, the healers' system of classification was specifically developed to facilitate the examination of the effect of a person's health beliefs in determining their course of action.

One of the reasons commonly cited to explain the use of non-scientific medical arts is a lack of congruence between a patient's and a physician's belief systems (McGorkle 1961, Scott 1975). As pointed out in Chapter 1, most investigators of unorthodox illness behavior have studied people whose belief and practice systems are markedly divergent from those of medical doctors, eg. third world cultures and American minority groups (pp.<sup>4-6</sup>). In this section, I present examples of the illness beliefs and healing philosophies of the sample patients in a search for an understanding of their illness behavior. These beliefs are seen to color and be colored by the patients'

illness experiences and behavior.

This section considers 3 aspects of illness and healing beliefs that were found to be associated with the use of unorthodox health care. The first part looks at the relevance of a person's conceptions of illness and healing philosophy to his/her unorthodox behavior. Next, I discuss patients whose behavior can in part be understood by their desire to use specific techniques employed by healers, but not available within orthodox medicine. The third part of this section reviews examples of patients who have chosen unorthodox care, in part, specifically because of their perceptions of the risks of scientific medical treatment.

#### Conceptions of Illness and Healing Philosophies

Healers were classified on the basis of their healing philosophies. Twenty-one (21) patients' conceptions of illness and/or healing philosophies resembled those of their current primary unorthodox healer Table 11G. The beliefs of patients who, at the time of the interview, used an unorthodox healer from more than one philosophical category, were found to resemble most closely those of the most current primary healer. In the section on Hierarchy of Resort (p. 275), the use of multiple sources of health care is linked with two theories: (1) a person has multiple needs at different times during the course of an illness that can only be satisfied by different people and (2) in view of the findings presented in this section, the use

of healers with different healing philosophies may reflect that a patient's beliefs change during his/her career of illness and help seeking. Unfortunately, because of the retrospective nature of method of the data collection, I cannot ascertain whether the belief changes occurred at all or whether, if they did occur, they antedated or postdated the change in utilization behavior.

Patient Ie, who used only physicians and healer I, presents a conception of illness and healing which is an amalgam of orthodox medicine's and her healer's. Her beliefs are also seen to be colored by her illness experience. She believed that disease was a distinct entity, "... a thing that eats away at your body." Osteomyelitis was preventing the union of her fractured tibia and fibula. She felt deserving of punishment and searched for some sin she may have committed. "God has done something about my health. This is His way of getting back at me for something I did. If I knew what it was, maybe I could undo it." Her illness was more than fractured bones. To her, it was a constant reminder that she had been bad.

Patient Ie did not initiate contact with Mr. Carbonella. She had asked to see a chaplain. After talking, the chaplain suggested to the patient that she might benefit from Mr. Carbonella's visits. Ie's healing philosophy is remarkable similar to Mr. Carbonella's. She believes that her doctors are instruments of God. "God has an integral role in my getting better. He

was with me in the OR yesterday. Dr. \_\_\_\_\_ is an excellent doctor, but he's also an instrument." Ie's ambivalence about her role in healing and responsibility for her illness is characteristic of the Fundamentalist philosophy. On one hand, she could not accept Mr. Carbonella's attempt at exculpating her. "He (Mr. Carbonella) told me that (the occurrence of the disease) was the way it was written in the book. I felt that's true, but also feel I had something to do with it. (As Mr. Carbonella would too.)" From this perspective, she feels that "I've got to do it (achieve health) myself." On the other hand, she feels powerless before God, "I just feel that when He's ready, it'll happen. No amount of praying can help." She is not sure whether she believes in faith healing, but she is willing to give Mr. Carbonella the chance to help, "I'm in the middle of the road, I'd have to see it." Without taking an active role, she is ready to be the recipient of God's healing power through Mr. Carbonella.

Since she was diagnosed as having discoid lupus erythematosus almost 20 years ago, patient IIIe had used healers from several philosophical categories (cf. Table 11F), as well as several within any given category. Now her conceptions of illness and philosophy of healing are remarkably similar to her current primary unorthodox healer, Dev Singh. She says,

I never say I am sick, I say I have a strange illness because the former programs you to being sicker than you are. In a funny way, I'm dealing with lupus as if it were someone coming to visit you in your apartment.

I'm treating it as if it were somehow separate from me. (compare with p.118).

Although she is not a member of 3HO and has only recently been attracted to the ashram, she has Dev Singh's same conception of a karmic purpose to illness, "I think that the reason I got Lupus was because the good Lord was telling me to learn to focus. Through suffering, you'll learn to be more sensitive to others and to help them." She says of her past search for health, and her recent revelation, "I've been turning to so many people for help that I tend to think of healing as out there and not in me. Now, I'm beginning to learn that healing is in me." She believes that "God is in myself."

Patient IVa is 8 years old. His mother had taken psychic healing classes with Mr. Grasso before her son was diagnosed as having an atypical ectopic pinealoma. She had already been convinced of the efficacy of psychic healing by its ameliorative effect on her migraine headaches. Her conception of illness and her philosophy of healing contributed to her choice of Mr. Grasso as a healer to be used in tandem with orthodox medicine. She believes that "A lot of disease is caused by an imbalance in your own system like prolonged negative attitudes." Like Mr. Grasso, she also believes in reincarnation and that "some people have certain diseases to learn something by." To heal, "it is necessary to tap into other energies."

As a patient, which the mother of a sick child can in some ways be considered, she sees herself as taking an active

role in healing. Mr. Grasso facilitates, but she must open herself and her child to the healing energies of a higher power.

Four (4) patients' healing philosophies and conceptions of illness were different than their healers'. Two of the patients (Ia and d) had not originally chosen their healer. Patient Id's beliefs are in striking contrast to Mr. Carbonella's. Only after Mr. Carbonella had initiated a relationship with her, did he tell her of his belief in faith healing. She continued to be receptive to his visits only because of his "bubbly personality". What she liked least about him was his faith healing, though she added, "As long as he doesn't push it, it doesn't bother me." Her conception of disease was that it was an "abnormal affliction of the body that can only be cured through the appropriate "specific (medical) therapy and psychological support."

Patient Ia was a nurse with a firm faith in the medical model of disease and treatment. Nonetheless, as pointed out in the section of Mr. Carbonella's relationship with his patients (p.272), Ia did attribute, a "special" quality to her healer that goes beyond the bounds of her articulated healing philosophy.

The reasons for the other two patients' philosophical conflict with their healers can also be discerned. One patient, VIId, did not comply with Ms. Kirbo's Reams program. Her problems had been quickly resolved during the Reams and psychic treatments. She felt now that the diet was "impractical".

In fact, at the time of the interview, her primary care was provided principally by one of Ms. Kirbo's psychic assistants. VIId's philosophy was more similar to his. It remains a matter of speculation whether her beliefs were originally more attuned to Ms. Kirbo's.

Patient IVC was a seriously depressed man with Parkinson's disease whose wife dominated all major decisions about his health care. It was she who had decided to consult Mr. Grasso. Her beliefs did more closely match Mr. Grasso's.

#### Perceived Benefits of Unorthodox Therapeutic and Diagnostic Techniques

Twenty (20) patients (Table 11G) stated that a contributing factor in their choice of healer was what they perceived as the potential benefits of a therapeutic technique not offered by their physician, e.g., Laetrile, psychic healing, nutritional counselling, yoga, etc. Five (5) of these patients were desperate-- they had exhausted all orthodox methods without relief. The other 15 patients simply believed in the greater efficacy of the healer's therapeutic techniques.

None of the sample patients specifically consulted their healer for diagnostic reasons, though several did go for better explanations of their diseases (cf. p. 266). The absence of this motivation is, in part, an artifact of the sampling method. I purposely selected patients with well-defined physical problems. As noted, most of these problems had been diagnosed by physicians.

Many non-sample patients, with whom I spoke casually, used the study healers specifically because of a belief in the healer's greater diagnostic sensitivity, eg. through psychic reading, Ream's testing, etc. (Healers III, IV, and VII).

Furthermore, several of the sample patients stated that they shared similar beliefs. For example, patient VII B said:

I think Reams urine analysis and spittle analysis is better than getting your blood pressure tested and maybe your sugar... I have more confidence in what they're able to tell you here than in any doctor's office... My son Joe went to the doctor last week. The doctor said, 'You're ok Joe.' But, he doesn't feel good. He's tired all the time. I brought him in here. Bette (Healer VII) tested his urine. She said, 'My God Joe! Your salt is so high. Your sugar is so high...' Well now I know he'll stop smoking, drinking, and eating bad food.

Virtually all of the 20 aforementioned patients revealed fascinating testimonials about the benefits they allegedly received through the use of an unorthodox technique. Whether they are medically verifiable is besides the point. It is the patients' perceptions which influenced their behavior. A few characteristics of the testimonials are worthy of discussion as they relate to the understanding of unorthodox illness behavior.

In the first place, the perceived benefits of a technique were not necessarily the most important motivation of a visit to a healer. The other variables considered in this chapter were often preeminent. (For example, cf. patient VII a, p.276). Secondly, many patients had tried other orthodox or unorthodox techniques previously without success, but claimed to, at least, be symptomatically relieved by the method of their current healer.

Third, the desperate patients had little choice but to use an unorthodox method. Fourth, the healers' ministrations most often would heal (or make the patient feel better) even if the disease or its physical manifestations were not cured. On occasion however, a patient was physically improved by a technique but not healed. Finally, patients tended to attribute their symptomatic improvement to the unorthodox healing technique regardless of the simultaneous use of orthodox treatment or the self-limited nature of the medical problem. The third, fourth, and final points are of particular interest and will be illustrated below.

One desperate patient (VII b) was not offered treatment by his physicians. They said he had an inoperable gastric cancer. Ms. Kirbo offered him Ream's therapy and Laetrile and along with them, hope.

One doctor was quite frank with me. He told me that I'd just get sicker and sicker until I was throwing up everything I ate. I'm not sure, but I think I might be able to lick it with Laetrile. I've got nothing to lose at any rate.

This patient had just recently begun unorthodox treatment and could not yet evaluate its efficacy. Two (2) other desparate patients, however, presented remarkable testimonials about the efficacy of their healers' techniques. One of these cases, patient VIIe, is presented later (p.280) as an example of an illness experience.

Patient IVc's case is particularly fascinating because

it represents the obverse of what, in my sample, so often occurred. Patient IVc's wife reported that the physical manifestations of her husband's Parkinson's disease were dramatically alleviated, but he was not healed. He lived in total despair, imprisoned by his disease. His wife declared his disease dramatically improved, but he did not concur. IVc had been under the care of several different doctors for over 10 years. His neurological and psychological condition relentlessly deteriorated until he was confined to bed with rigidity and dysphagia. He was depressed, suffered paranoid delusions, and, at one point, in a frenzied rage allegedly attempted to strangle his wife. He had run the course of standard medical treatment, and now, under the care of an internist and psychiatrist, was taking Artane, Symmetrel, Benadryl, Sinequan, Dilantin and Prolixin. Desparate, his wife was referred to Mr. Grasso by a niece who was in a psychic healing group at the Psychic Institute (cf. p.143).

Lenny (Healer IV) came in the middle of the snow. It was as if God had sent him. In time of need he was there snowstorm and all. At this time, (IV c) was very twisted, rigid and in pain. Lenny came almost every night.

Mr. Grasso was able to effect instant symptomatic relief, which I actually observed (cf. p. 147). Between sessions, the patient relapsed, but gradually over 18 months, his wife reports, he progressed to his current state of relative full function. She says that everyone close to him recognizes a dramatic

improvement. The patient himself, however, refuses to acknowledge his improvement. Based on my observations the wife's claims appear to be accurate.

Patient IVd used orthodox medicine in tandem with psychic healing, but she attributed her healing to the psychic treatment. She was sent to the emergency room in an ambulance by her husband who was frightened by his wife's sudden complaints of vertigo, uncontrollable vomiting and difficult walking. What she perceived as a "psychic attack" was diagnosed as being labyrinthitis. Over the next 4 days she consulted Mr. Grasso for psychic healing and took the Antivert prescribed for her. By the fifth day, she had recovered completely. She acknowledged the effect of the drugs, but attributed greater potency to the psychic healing.

If a particular unorthodox technique did not work, some patients would rationalize resort to an orthodox method. Then, they would ultimately attribute recovery to their unorthodox technique. Patient IIIe's self care and consultation of Dev Singh had not helped his infected dyshidratic eczema. He ascribed the failure of 3HO methods of helping to his own shortcomings rather than to the 3HO methods (cf. Festinger 1956 ).

On the advice of a Sikh healer, he went to the emergency room where he was prescribed antibiotics. His 3HO healer told him in some cases "... the best thing to do is to take antibiotics." He said sure I "could cure it, but how long

would it take? You have to work and do other things. Besides, there are things you can do to purify your system of drugs." I talked to him a few days after he began his course of antibiotics. When asked what effect the drugs had had on his recovery, he said, "They've made me sleep a lot more. I guess they've also had a beneficial effect, but that's a hard question to answer. As soon as I started taking the drugs, I started improving. But taking the bottle (of drugs) before the Guru and blessing it had a lot to do with it."

#### Perceived Risks of Orthodox Treatments

Eleven (11) patients specifically stated that they preferred using an unorthodox therapeutic technique because they feared the risks of orthodox treatments (Table 11G). On these grounds, a group of 7 patients were adamantly opposed to all medical interventions unless absolutely necessary. These patients were also those who were admantly anti-medicine (Table 11I). The other group of 4 patients had sought unorthodox care to avoid or to wean themselves from what they perceived as the iatrogenic complications of a particular medical regimen that had been prescribed for their present illness.

The majority of the first group were "natural freaks", i.e., they believe, on principle, that medicine's synthetic drugs and surgical procedures invariably, in the long run, caused more harm than good. Natural methods, used by patients to describe such methods as homeopathy, nutritional supplementation,

Laetrile, psychic healing, etc., were considered at worst harmless. Some of these patients attributed special (Vitalistic) properties to natural healing methods. Others simply were skeptical that humans could make something (eg. a drug) as well as nature (eg. an herb). One of these latter patients (VIIe), was surprised when I clarified her misconception that only synthetic materials were made of chemicals.

The second group of patients is exemplified by patient IIIe. She had been taking anti-malarials and steroids for control of her discoid lupus erythematosus. She sought unorthodox healing to wean herself from these drugs. She wanted to start a family and felt uneasy conceiving while taking an anti-malarial which is contraindicated during pregnancy. She also was sophisticated in her knowledge of the complications of long term corticosteroid treatment.

#### The Healer-Patient Interaction

In this section, I review some of the expectations and disappointments of the sample patients' in their relationships with orthodox physicians and healers. Three broad groupings of expectations unmet in the patient's experience with medical doctors were found to be associated with use of alternative healers: personal qualities of the doctor (healer), explanations of a given illness, and role of the patient in the treatment process. A final section is reserved for discussion of the unusual and unexpected characteristics of Mr. Carbonella's

relationships with his patients.

#### Personal Qualities

In discussing their expectations of the personal qualities of a healer (doctor), patients spoke of both negative and positive characteristics. Eleven (11) patients pointed to particularly noxious aspects of their physicians which led the patients to expect no better within an orthodox framework (Table 11G).

Thirteen (13) patients (not necessarily the same ones, see Table 11G) expected their healers to possess certain positive or special qualities.

Noxious qualities that turned patients away from their orthodox medical doctors were such commonly criticized characteristics as lack of personal involvement with the patient, aloofness, pomposity, hurriedness, indecisiveness, treating money rather than the patient and narrowmindedness about unorthodox therapeutic techniques. Two examples flavor these criticisms. Patient IVc's wife recalls her dissatisfaction with the discontinuous care of her husband in a Veteran's Administration's clinic.

We never would get the same doctor... After about 3 clinics, I started carrying my own chart because if they didn't want to read the chart I wanted to make sure they knew the facts... Some doctors won't even check you. They just talk to you, 'Hello, how are you? What medicine are you on? OK, why don't you stay on it.' They don't even test your reflexes, check your heart or anything... You feel so dissatisfied when you leave.

Patient Ic complains that doctors never respect the experience

of the patient:

Doctors don't listen to their patients. They won't believe that I've been through four operations in the last eight years and I've come to learn my body pretty well. For example, I know if I'm given a major anesthetic that as long as I'm confined to bed I won't be able to move my bowels or urinate. Every time I tell people about this they'll say 'oh well we'll try it our way this time.' So after the operation when I'm confined to bed they'll use a catheter every 3 to 4 hours. I don't see why they won't put a foley in and leave it in for the first few days after my operation. Instead they insist on catheterizing me every few hours several times a day. I don't know if you've ever had to lie on an incision but it's extremely painful. It usually takes them 30 to 40 minutes each time they catheterize me. They admit that they don't get much experience catheterizing women (staff). Well by the time they're finished, I'm a wreck. I'm irritated and sore down there where they've been bothering me. I'm humiliated and embarrassed and tremendously aggravated. I know that leaving the foley in may increase the chance of infection, but I think that that's probably worth it for me to avoid the psychological damage, which in my case is worse. Instead, you get the feeling that the doctor just thinks of you as a patient in a bed and that they're running the show. They refuse to listen to my ideas.

Positive personal qualities that patients expected (and received) from their healers were of two major types. One type was the obverse of the noxious personal characteristics that had soured the patients' relationships with physicians, eg. personal attention, openmindedness, accessability warmth, etc. The other type was a more special quality-- a healing presence.

Patient Ia's appreciation of her relationship with Mr. Carbonella exemplifies the first type of personal qualities cited by the patients as important in a healer.

Joe has a great thing about understanding problems. There's a guy you can talk to who looks at you not because you're a skeleton or a patient, but because

I'm me.

Patient Vb says of Dr. Lowkap:

I like his manner, his patience. If I call him on the phone, he's never too busy to talk a bit. He always says, 'Call back and let me know how you're feeling'-- which is different from most doctors who want to limit their contact with patients, and also who only want to see you if you're still having problems.

In Mr. Grasso, patient IV c and his wife found a man who epitomized the opposite of their experience in the Veteran's clinic. For the first several months of their healing relationship, Mr. Grasso would spend several hours healing IV c every evening at IV c's home. Since those early months, Mr. Grasso has gradually tapered his contact with IVc to two 30 minute sessions a week, but he remains always accessible.

Some patients were looking for more than just a warm concerned person. They expected their healer to have a special presence which denoted his/her relationship with something greater than him/her. This expectation was discussed as one of the main themes that pervaded the case studies of the healers. Patient III D encapsulates, with his specialized vocabulary, several patients' desire for a "gifted" healer.

The most important (quality of a healer) is their aura energy. I don't care if he has all these medals and certificates. You can take a person off the street with these (aura) qualities and he can be a better healer than someone who has been to schools.

This patient went on to add another healer quality important to several patients. "The healer must learn how to channel these energies or else he may take on the sick person's

Karma." For the healer to help, s/he must be healthy. S/he must as patient V b says, "practice what he preaches." (cf. chapter 10).

### Explanations

In their use of unorthodox healers, several patients stated that they were looking for more satisfying explanations of their illness than their physicians had given them (Table 11G). Two (2) patients wanted a better physiologic understanding of their medical problems. A larger number, 8 patients, chose their current alternative healer specifically for a spiritual (or psychological) interpretation of their problems.

One patient in the first group was Ic, who was hospitalized for a laminectomy.

No one really explains anything to you. For example, my doctors didn't tell me that I'd have drainage tubes in my back and that that would be painful. I figured from previous operations that the pain should be decreased after 3 days. When that didn't happen, I was worried that something was wrong. One morning, Joe (Healer I) caught me crying in my soup. He explained that the pain was due to the tubes and that with this kind of operation one can expect setbacks. Later when the tubes had been taken out and I discovered that Joe was right, I began believing everything he said. By telling me what to expect, everything was a lot easier.

Patient III b had been plagued for years "with constant belt pains around my lower ribs,"

I went to every doctor possible. All the clinics. Lots of tests. But they never gave me any diagnosis... At this point I had totally resigned myself to going to the hospital as much as once a week for a shot of demerol. The doctors kept saying nothing was wrong, but I was in so much obvious pain they'd keep giving me the needle.

One reason for this patient's decision to become a member of ZHO was because "they had answers for just about everything-- whether it was medical or spiritual. And the answers weren't just personal opinions. They were backed up by the words of famous doctors or by spiritual experiences."

Patient IVe knew that she had granulomatous colitis, but she needed to know "why me?". She believed that,

we create our own disease. All of it is in our head. I realize germs exist, but we set ourselves up. It's a decision we made-- obviously not necessarily consciously... I still feel if I could find out exactly why I had it, I could be healed... The only thing a doctor can do is give me medicines to control it, and I don't count that anymore.

On the recommendation of a friend who knew Mr. Grasso, IVe consulted him for a psychic reading before beginning with his healing treatments. The explanation she received was not, however, what she expected.

He says that the major reason I have this problem was because I was a prostitute in France 2 lifetimes ago, and I didn't do too well last time around either. It's part Karma now. I'm dissipating energy through the sex center. This explanation didn't make me feel too good. It only worsened my depression.

Nonetheless, IVe continued to consult Mr. Grasso primarily because of faith in his healing technique. (Also, refer to patient Ia regarding her need for a metaphysical explanation of her problem, p.273).

One other patient (IIIc), unique in this sample, resorted to unorthodox care specifically because he wished to deny his doctor's physiologic explanation of the patient's illness.

His denial interdigitated with the conception of illness and healing philosophy of his healer. When he was told by his family doctor that he had a form of leukemia, he says,

I didn't want to know what the disease was or what it could do to me... My feeling was I'd reject it. The only way I could beat it is to reject it. What's wrong with me? Look at me, my hands don't tremble. I put in a good day's work. So why should I admit it? I was never one not to see a doctor. I always did until this diagnosis. They were going to give me medicines and all. I didn't need to be reminded about it every week. I can talk about it. But I don't want people at work to know about it. It would hurt my job.

Evidently, he was tortured by his knowledge and pressured by his family to do something. He could not talk about it comfortably. During our interview, he became increasingly agitated. His choice of a Perfectionist, Dev Singh, was particularly relevant to his desire to reject his disease. He was given a 40 day steamed celery fast to purify his body, yoga and meditation exercises for relaxation, group healing for emotional support, and spiritual counselling which supported his need to believe that he could reject his disease.

#### The Patient Role

Fourteen (14) patients' (Table 11G) use of an alternative healer was associated with a specific desire for a more active role (█ or ▲) in their treatment process than they had been afforded in orthodox medical practice (█▲)? These patients differed in their beliefs about their role relative to a higher power, but all of them believed that healing was a process

in which the patient must assume a responsibility equal to or greater than the healer. They concluded, then, that they should be permitted to take an active part in the decision making regarding treatment and that they should play a major role in actually effecting the treatment.<sup>8</sup>

Philosophically, all of the healers I, III, IV, V and VII concurred with these patients about the relative responsibilities of healer and patient. As noted in chapter 6, 7 and 9, in practice, healers did not always interact with patients according to this ideal. Thus, ashramite patients IIIb and d were placed in the position of taking the authoritarian advice of Dev Singh. All of the remaining patients (including those of healers VII and IV) who wanted to share responsibility in their relationship with their healer were able to do so.

Patient IIIc, just described in the previous section is one example of a patient's using an unorthodox method to take control of his own treatment. As is exemplified below, a patient's active role in a healer-patient relationship took several other forms.

Patient VIIb had little choice. His doctors were indecisive and whatever treatment they could offer they admitted would be of little benefit.

Most of them (the doctors) said that I shouldn't have surgery, but there was one who said I should be operated on within 3 days... The conflicting opinions of the doctors made me the one who had to make up my own mind... My family decided that we'd better do something about it.

VIIb likes Reams therapy because, as he says,

I feel like I'm participating. If an MD said the same thing I'd do it. I've read all about the Reams program and it makes sense to me. I've got to go out and get water and vitamins and follow the program. I put myself in their hands to the extent that I take their recommendations about vitamins and diet, but if they were to suggest that I go to the drugstore for a prescription drug, I wouldn't take the advice.

Nine year old patient Vb's mother says, "I have to participate in my health care. Dr. Lowkap doesn't come across like a God, in an authoritarian manner. Do this, this, and this or else don't come back. He bends to your need."

Patient IVa's mother could not relinquish her control of critical medical decision making to her doctors. She has aggressively pursued multiple orthodox opinions and consulted with a healer (IV) who affords her a very active role in the treatment of her son. (Parenthetically, her case also provides an excellent example of one of the ways that a person uses an unorthodox healer in conjunction with orthodox medicine.)

...the pediatrician I went to for so long with Jimmy (patient IVa) didn't know what was wrong, he would negate it (her complaints). So many people think of doctors as Gods. You come in with tremendous pain and if he can't find anything wrong, that's it. The end of the avenue.

Rather than letting her pediatrician call her "just another spastic mother", she sought other medical opinions. She had begun psychic development courses and "sensed" that her son had a brain tumor. After consulting many orthodox specialists over the course of a year, a positive pneumoencephalogram finally confirmed her impressions. Unfortunately the procedure dramatically

changed the patient's mental status, so that all he would do was clap, whistle and say nonsense words.

The doctors wanted to operate the next morning... They would give him radiation but they couldn't save his life. This we weren't prepared for. We wanted a second opinion. They said he could not live more than 1 year. We took him out of the hospital (where he was in an intensive care unit). They gave us a really hard time. They said we were looking for miracles. They didn't give us any hope. If he was going to be operated on, I wanted the best, not \_\_\_\_\_ hospital. We took our son home. It was very scary. We didn't really know what we were doing. Our son was in imminent danger.

Ultimately, she brought the child to Boston Children's Hospital. She reports that "they advised us against operating. They told us that the only chance would be irradiating." During his hospital course, the patient underwent many tests and at one point deteriorated markedly with increasing intracranial pressure. The patient's mother called on her healing group and Mr. Grasso to join with her in projecting healing "energy" to the child. She reports that through her efforts she was able to decrease her son's intracranial pressure, as well as calm him before diagnostic or therapeutic procedures.

Whether due to the psychic healing or the orthodox treatments, the patient has reportedly made a startling recovery with progressive improvements over the past 3 years allowing his normal participation at school. This mother perceived her role as key in the healing of her son. Her aggressiveness in seeking multiple orthodox opinions may well have saved the child's life. But she too, as a mother of a young child, can be considered a

patient. She was "sick" with a sense of helplessness. Psychic healing gave her something to do. As she puts it, "a lot of what psychic healing did was also to relax me, so I could do something useful rather than be spastic."

#### The Special Cases-- Mr. Carbonella's Patients

Mr. Carbonella's relationships with patients in this study is unique for two reasons. First, he initiates contact with patients. Second, he purports not to tell his patients that he is a faith healer, though he considers faith healing of pre-eminent importance in his relationship with patients he has chosen to heal. Actually 3 of Mr. Carbonella's patients interviewed for this study (Ia, b, c) knew him from previous hospitalizations and requested his services. All were told by him that he was a faith healer. Only one of the 5 patients specifically believed in faith healing as a technique. That one patient (Ic) did not accept Mr. Carbonella as a faith healer per se. These facts would have surprised Mr. Carbonella because he presented them to me as people he felt were particularly receptive to his techniques, however clandestine he purported to have been. Nonetheless, all but one of the patients (Id), intimated that there was something particularly special about Mr. Carbonella which they felt was highly relevant to their physical as well as emotional well-being. In other words, if nothing else, they recognized that the mere presence of Mr. Carbonella was healing. Of great interest is that the only

patient that denied this special quality was patient Id, who Mr. Carbonella had just begun working with. Each of the other patients had spent literally many months under the care of Mr. Carbonella. At this point many of their comments suggested that as sophisticated and medically oriented as they were, it was difficult for them to admit either to me or probably even to themselves that they had come to believe in faith healing (cf. Chapter 5, p.109).

Before presenting some quotations which have led me to this conclusion, I refer the reader to the section on Illness beliefs and Healing Philosophies ( p. 250 ) where I have already noted that patients Id and Ia did not share their healer's healing philosophy. In that section, I cited striking parallels between Ie's and her healer's healing philosophy that resembled similar parallels for patients Ib and c.

Patient Ia is a nurse whose career interests led her ultimately into primatology. She is an upper class woman (class I) with a strong scientific background and a strong medical orientation (in spite of some horrendous iatrogenic complications of multiple surgical procedures and polydrug treatments). She says, "I'm a nurse with a scientific background. I don't believe in that faith healing stuff." Nonetheless, she states her conception of the reason behind her illness in almost the same terms as Mr. Carbonella would, "Sometimes I think I've done something wrong earlier in my life and I'm being punished...,"

characteristically she then qualifies, "but how can I believe in that because I don't believe in God." Later, in the interview, she implies that rather than being atheistic she feels forsaken, "Maybe there is a God and maybe not. I've had so many things happen to me. I couldn't believe that God would do some of the things he's done. It's hard to have faith. Every once in a while I have to grab on to it for reasons unknown to me." She then offers that actually, "she prays a lot, but never with Joe. But he has prayed for me and I encouraged it especially when I had lots of pain."

Patient Ib says, "It does mean something to me that Joe prays for me. I don't believe we're all capable of that much faith. Obviously, his faith must be of benefit to me, but there is no way of knowing for sure." More directly, he admits, "I didn't know that Joe believed in faith healing until today. But obviously there must be something to it, because of the way he helped me. If someone believes in something as strongly as he does, it's bound to rub off on you provided you have faith in him."

Patient Ic is closest to acknowledging that she recognizes Mr. Carbonella as a faith healer. In fact, she admits to believing in faith healing as a technique. She says, "I believe that some people are healed through faith, but I'm not sure that you need the go between for faith healing." She says about Mr. Carbonella, "I don't believe that he gets the power from God to heal you."

Rather, he may give you the strength and faith to get it directly yourself from God." Yet, in another statement, she accords Mr. Carbonella a more special role, "I feel that if I had enough faith, I wouldn't need someone like Joe to intercede for me." Finally, she recounts what her "healer" has done for her.

A great deal of my recovery is my attitude-- how I've learned to live with my problem. It depends what your definition of a miracle is. If one day I'm so depressed I can't imagine living (she was suicidally depressed), and the next day I decide that there's a lot to live for and that I can live with my condition and I get up and around-- that's a miracle.

I'm impressed that, over many months, Mr. Carbonella taught these people what took him a long time to learn-- that healing is different than curing. To the extent to which his patients learned this lesson, they believed in his power to heal.

#### Aspects of the Illness Experience

##### Hierarchy of Resort

In chapter 2, the concept of hierarchy of resort was introduced. Briefly, the idea is that people seek aid from different people, at different times, for different reasons. The notion of hierarchy implies that there is an ordering of these consultants. It was also pointed out that linked with the concept is the view that illness is a process, rather than a discrete episode in time. Considerable evidence documents that the sample patients used multiple sources of health care. This section provides support for the concept of a hierarchy of resort. Examples are provided that document an

ordering of the sample patients' choices of consultants which are linked with the course of their illness. The illness is seen to include patients' significant others. Concurrent use of more than one consultant is shown to stem from the multiple needs of a patient not satisfied by one healer. It is also evident from these examples that a hierarchy of resort is ordered, not simply by the socio-cultural context of a patient, but also by his/her unique experiences.

Patient VIIa, for example, recently began using an unorthodox medical doctor (Healing philosophy VII). She continues to visit Ms. Kirbo, but her current primary source of care is the medical doctor. She says about her tandem use of healers,

Sure there are conflicts between Reams and Kelly's (the nutritional regimen that her new healer prescribes). I decided to switch from Reams to Kelly's because I want an MD who can look and tell me what's happening. Also I can satisfy my husband who I don't want to worry. If the Reams program told me OK now you're healthy, no one would believe it. In this society, people will only listen to MD's. I am doing this mostly for my husband.

In taking this action she was responding to increasing pressure from her husband-- a significant aspect of her illness experience. Why does she continue to consult Ms. Kirbo? "I feel love when I come here. My illness decreases because they're (Ms. Kirbo and her psychic assistants) giving me positive thoughts."

Patient VIIb makes several points germane to the understanding of hierarchy of resort. During his current illness (gastric cancer), he had lost 50 pounds before his family began

to think it was not simply a concerted dieting effort that was behind the weight loss. After consultation with family and friends, he resorted to an orthodox physician for an explanation of the meaning of his symptoms. His physicians told him he had gastric cancer and that there was nothing they could offer him. Wanting to take some action, rather than simply waiting to die, he consulted Ms. Kirbo for Laetrile and Reams therapy-- his only current type of care. But he says, "For instance, if I reach a point where I want to compare where I was 6 months ago and now, I'd have to go get x-rays and then I'd be back in the hands of a doctor."

VIIb also exemplifies another common behavior-- different practitioners are used for different problems:

I really have an open mind. I think there are times when you need an MD and other times when other practitioners are helpful. For example, I'd go to a doctor for pneumonia or a heart attack and sometimes there are cases like where there is an intestinal blockage where you have to operate (which may well occur during the course of his present illness). But doctors take care of what has happened after the fact, rather than before. I've had good experiences with doctors, but could never figure out why they would always poopooch chiropractic when chiropractors could cure me, just like that, of a problem that they (doctors) couldn't cure for years.

Patient Vb, a nurse, exemplifies a hierarchy of resort in which an orthodox physician is the last health practitioner to be consulted. She says simply, "I explore every possible avenue before I will use a doctor."

In the next section, the illness experience is more fully explored. The examples provide a more complete picture of the

process of decision making that leads a patient from one consultant to another. In Chapter 13, the implications of patients using healers with different healing philosophies are discussed.

### The Illness Experience

Many of my patient interviewees complained that their physicians would not listen to them. They said that their doctors seemed too pre-occupied with their own questions, interpretations, or busy-ness to listen to how a disease had affected a patient's life. In short, doctors appeared to these patients as more interested in a patient's disease than his/her experience of illness. In this section, I first present an example of a patient whose doctors dismissed as insignificant, symptoms which troubled the patient. Next, I present what two patients were unable to tell their unreceptive doctors. These stories point out that the symptoms that the doctor so often focusses on in his/her history taking, are seldom the only, or the most important, reasons that the patients had decided to consult the doctor. The experience of symptoms is highly personal-- a function of a person's socio-cultural and personal contexts as well as of the stimulus (Zola 1972). One person's pain is not the same as another person's pain (Zbrowski 1952). The patients presented show that their doctors failed to attend to the patients' chief complaint or worry. These needs, unsatisfied, were met by unorthodox healers. This section concludes with a presentation of the chief complaints abstracted from all of the patient

histories.

Note that many factors already discussed as influencing a person's choice of health care arise in the following accounts. Together, they serve as guideposts which help explain these patients' pathways to healers.

Patient VIId is a 21 year old physical therapy student who presented to Ms. Kirbo and her psychic assistants with problems related to her menstruation. Her doctors had not pursued her problem further than a strictly biological assessment and treatment regime.

When I first went to the gynecologist, I thought he was really nice. He didn't seem quick with me. He told me I was perfectly healthy-- that lots of girls have problems with their period. It seemed like I was going to the gynecologist every few months at \$20 each time. He kept telling me everything was alright, but I knew it wasn't.

I didn't understand. My mother had never had any problems. I don't understand very much about my body functions. I wondered if I were to have sex, how would I know if I were pregnant?

Finally, the gynecologist put me on the pill for 3 months. It straightened me out, but I gained 10 pounds, which I couldn't afford. So I stopped taking them.

At this time, the patient began dating one of Ms. Kirbo's assistants. He suggested to the patient that she come to the clinic for evaluation and treatment. She began the Reams program and then counselling with one of the psychics. Menstruation was explained. She reports that her periods are now normal and that she has a new sense of self-confidence.

Patient Ic is a 34 year old class III woman, who has

had multiple operations for herniated discs and was admitted to the hospital for laminectomy and fusion. Some of her complaints about doctors who do not listen to patients have already been presented in the section on personal qualities of healers, (p. 264). She had met Mr. Carbonella on a previous admission and specifically requested his help now.

What really bothered me was how my condition would affect my relationship with my daughter. Even if I didn't couch my questions exactly like that, that was what was behind them and that's what I wanted to talk about.

It seems that most doctors are in a hurry. They will only answer the bare minimum of questions. I have never felt that I could take 15 minutes of a doctor's time to sit down and tell them what the problem really was. I feel like they're always looking at their watch. It seems like they only want to talk about what's directly related to the problem from their point of view, but what is indirectly related for them is usually the problem for me.

I wondered how could I best take care of my daughter. Whether having or not having an operation would affect this, was my main concern. If any doctor had just taken a few minutes to discuss this, it would have greatly relieved me. (emphasis mine)

Patient VIIe is a 44 year old class III woman, married for the second time 3 years prior to this interview. She had been followed by a rheumatologist and dermatologist for rheumatoid arthritis and psoriasis. Six months ago, she terminated her relationship with these doctors because (1) they did not hear complaints and (2) they would not allow her any control in her treatment. She then began consulting Ms. Kirbo and her assistants, the psychic healers. In order to give a full picture of this patient's illness experience, she is quoted without interruption

as she told me her story.

It first started when I had a total hysterectomy for fibroids a year after my second marriage. After the operation, I couldn't remember anything, or retain anything I read. It was of great concern to me. My doctor told me that it had been a very difficult operation lasting not 2 hours, but 5 hours. He said they almost lost me.

I just didn't feel like myself. I had no pep or energy. I had no memory. It was very traumatic. I thought something may have happened to my mind during the operation.

Then the terrible hot flashes began. They gave me estrogens. I would answer my husband in a way I couldn't believe would come out of me. When I went back to the gynecologist, he asked me, "Do you ever have the feeling you never want to live another day?" When I told him yes, he said, "Why don't you see a psychiatrist?" I think it might have been my daughter who called to tell him how I was acting at home. If I was depressed before, now I was in the pits. I couldn't believe that people thought I needed a psychiatrist.

I attributed it all to the fact that I was thrown into menopause suddenly, without preparation. He had given me a pamphlet, but it hadn't told me anything about the kinds of feelings I would have. My doctor didn't talk to me at all about it-- what to expect.

My husband didn't come near me sexually. At times this upset me a great deal. I felt I must have been less attractive as a women. When we got together sexually, all would be better for a while, but that was very infrequent.

It was when I was reading ladies' magazines that I first heard about the relation between hormones and cancer. I got scared. I quit taking them without consulting the doctor. After being off them for a short while, I can't tell you how good I started to feel. The hot flashes were bad, but I was feeling more and more happy.

Everything was going fine until my heel pain started when I was working at our restaurant. I thought I needed corrective shoes. My doctor suggested arch supports but it kept getting worse, month by month. I went to Dr. \_\_\_\_\_ (a rheumatologist) on the advice of my doctor.

At this point, the patient detailed her drug treatment. Her

joints became increasingly more painful, so that finally her rheumatologist said,

I would need gold salts. My joints were popping up all over the place. I was losing tremendous amounts of strength. I couldn't even hold up a frying pan. I could barely cook and I loved to cook it was my thing. Every thing I touched dropped or broke. It was total frustration. I was hardly able to get in and out of the bath tub or to comb my hair. I'd have brat fits. At its worst, it got to the point where I could barely walk up stairs. To do washing was almost impossible. Everything was piling up on me. I hate to do housework and yet I began to feel guilty.

After the operation I felt bad enough about myself. Then when my joints became deformed I felt even more ugly and it was painful to make love. I asked my husband why he would never make love with me. He said he was afraid of hurting me. I went bananas. I said let me make the decision on that.

When my doctor told me I would need gold salts, I asked him if there was any special diet I could use. He said, "No, God rest Adelle Davis' soul. There is nothing you can do other than eat a balanced diet." I had begun to read Adelle Davis and it seemed that according to her, something could be done by diet. Also my mother used to read things which said that diet could be helpful.

I never have taken to medicines well. I don't like taking it. I said well here I am, an uneducated woman and he's the all knowledgeable MD, but I decided to ask him anyway... to help myself. I didn't just want to take his pills. When he poopoed it, he really shot me down. He took away anything I could do for myself. He just would give me the pills and that was it.

He told me, 'Well, I can guarantee you one thing, you'll never be a cripple.' I'm sure he said this because he could see that's what I was afraid of because in the last few months my arthritis had progressed so quickly. I was scared out of my wits. So he could offer me that. But I knew inside that I wasn't helping myself. I wasn't taking any active part in curing myself.

This doctor thought of himself as an eloquent speaker, an orator. He'd talk about other cases but use words that had no meaning for me. They were far above me. He really

seemed to be enjoying himself going on and on, but what I wanted to know about was me.

Right after leaving the office, I stopped in at Banta's health food store (see p. 78) and asked for help. He suggested a book by Dr. Carey Reams.

Mr. Banta also referred the patient to Ms. Kirbo. She began Reams therapy. Within six months she had regained full function. Her only symptomatic residue was occasional soreness in her fingers. Several months after beginning Reams, she was referred to one of the psychic healers by Ms. Kirbo. With him, she had begun to tell her full story.

As can be seen from Table 11L, the 3 patients presented are not remarkable for the patient sample. Virtually every other of the 25 patients similarly presented to me chief worries that had pre-occupied them during their illness. These worries served as principal instigators of the patients' decision to seek health care in the first place. Physicians who treated diseases without attending to the major needs and worries of these patients contributed to their decisions to seek unorthodox care in search of what the patients called healing.

#### Intuitive Factors

Undoubtedly, many unconscious factors, which were not pursued during the interviews, have affected the patients' illness behavior. Some patients did specifically mention some intuitive factors which influenced their health decision making. These factors included dream content, visions, psychic messages,

MEDICAL DIAGNOSES, CHIEF SYMPTOMS AND COMPLAINTS

TABLE 11 L

Patient Number	MEDICAL DIAGNOSIS	CHIEF SYMPTOMS	CHIEF COMPLAINTS
I A	Herniated discs, vertebral collapse	Pain throughout body	Pain, lonely, labelled a malingerer
B	Renal colic	Flank pain	many family burdens
C	Herniated discs	Back and leg pain	What is cause of pain
D	Persistent vomiting, weight loss	Persistent vomiting, weight loss	Interferes with functions as mother
E	Compound fracture of tibia and fibula, osteomyelitis	Leg pain, fever, bedridden	Too many burdens to carry
III A	Broken nose, facial lacerations	Painful swollen nose and face	Dependency, emotional and financial drain on family
B	Scoliosis, recurrent abdominal pain	Abdominal and back pain	Disfigurement, pain, need for support and comfort
C	Leukemia	Increased drinking, sleeplessness	Drug dependency, insecure life style
D	Infected dyshidrotic eczema	Painful, disfigured, swollen glands	Unhappy, poor relations with family
E	Discoid lupus erythematosus	Facial rash, fatigue	Interferes with work
IV A	Ectopic atypical pinealoma	Polyuria, precocious puberty	Interferes with ability to have a family, career, and social life
B	Bronchitis, asthma	Cough, trouble breathing	Mother: feels useless, helpless, and anxious
C	Parkinson's disease	Rigidity, bradykinesia	Misses many school days, interferes with social life and physical activities
D	Labrynthitis	Vomiting, vertigo	Patient: hopeless, unpredictability of rigidity. Wife: lack of control, he tried to kill me, his negative attitude
E	Granulomatous colitis	Chronic diarrhea	Dependency, interference with daily life
V A	"Stiff neck," sleep disturbance	Stiff neck, trouble sleeping, emotional tension	Why me? Loneliness, ex-husband has affairs when she is sick
B.	Poison Ivy	Pruritic skin lesions	Spiritual trial
C	Hypertension	Emotional tension	Mother doesn't want him to depend on steroids
D	Upper respiratory infection	Hoarseness, malaise	Wants someone to talk to
E	Recurrent pharyngitis, allergies	Sore throats, nasal congestion	Doesn't want to spoil public image of perfect health
VII A	Cervical cancer	Vaginal bleeding, weakness	Mother: doesn't like way son breathes through mouth. Makes him look goofy and unintelligent
B	Gastric cancer	Weight loss, early bloating	Wants love
C	Ulcerative colitis	Chronic diarrhea	Wants control over life.
D	Dysmenorrhea, irregularity	Menstrual cramps, irregularity	What me? What is body telling me, What can I do, loneliness
E	Rheumatoid arthritis/psoriasis	Painful joints, skin lesions	Doesn't understand body, not as good as everyone else
			Need for love and sexy attractive body

and chance happenings.

Patient VIIa vividly describes the intuitive cue that initiated her trip to the doctor for a pap smear.

I had a terrible dream that warned me that I might have cancer. I dreamed that I was in a classroom and then on leaving class I said, "Oh I have to go to the dentist." The dentist wasn't in and on leaving his office I met a red haired jolly woman who would read my skull. She began and was jolly, giggling, then she said, "Oh my God! (giggle) You only have one year to live." Then I woke up and was thinking that I felt fatigued and dizzy sometimes. I also was constipated for the first time. Plus, my period had decreased to 10 minutes per month.

In a pre-test of the patient interview schedule, a patient of a Spiritual healer told me how his dreams had become like "prescriptions" for his illness behavior. His healer encouraged him to listen to this intuitive side of himself by "incubating" dreams (roughly, deciding what to dream about before going to sleep) and by encouraging hypnagogic states of consciousness. Mr. Grasso similarly trained his patients in psychic development classes to attune to psychic messages about courses of action regarding health. One patient (IVb) reported that she had recently begun receiving such messages.

Dev Singh also taught his patients to be sensitive to their inner self. In fact the inner self was to be trusted more than the rational self. One of the ashramites (IIId) said, "I've given my head to the Guru. I'm no longer in control of my life."

Finally, from the patients' description of their de-

cisional pathways to the healers, it was apparent that choices of healers was affected by simple chance occurrences.<sup>9</sup> For example, there was by chance a health food store around the corner from patient VIIe's rheumatologist (see p. 283). Having made the decision to take her health care into her own hands, she was driving home from her physician's office when she saw the health food store. This store "happened" to be one which was active in dispensing health advice (p. 78) and which regularly referred patients to Ms. Kirbo.

#### SUMMARY

The sample patients, their utilization behavior, and factors associated with this behavior have been described. The patient sample has been shown to include people who are remarkably different than the stereotyped utilizer of unorthodox care discussed in Chapter 2. Of note regarding the patients' utilization behavior is that patients reported having multiple sources of health care that could be ordered in a hierarchy of resort. Each person's hierarchy of consultants was seen to be unique. Most, but not all patients, consulted an orthodox physician before resorting to a healer for the present illness. About half of the sample are now using only a healer for their present illness. The other half, however, continue to use a medical doctor concurrently with a healer. Several patients have used more than one healer for their current problem.

Resort to consultants beyond the first contact with a health provider was seen to reflect the multiple and changing needs of the patient during the course of an illness.

Variables associated with the choice of an unorthodox healer were found in six broad areas of information collected from the patients: past illness experiences and behavior, medical skepticism, social context, illness and healing beliefs, aspects of the healer-patient interaction, and aspects of the present illness experience. Several factors, as summarized in Table 11G, were identified within each of these areas. Intuitive factors were seen to operate in a number of cases as cues to initiate the seeking of health care. The next section will discuss these findings and the case histories of the healers with reference to the extant literature on illness behavior. New avenues for research will be proposed.

## CHAPTER 11 FOOTNOTES

<sup>1</sup>As is pointed out in the section on source of care for present illness, only 3 patients did not see an orthodox medical doctor at some time for their present problem. These 3 patients contacted Dr. Lowkap, a medical doctor, albeit unorthodox.

<sup>2</sup>One (1) patient (II B) had just been separated from her architect husband and stated she had too little money for the regular chiropractic treatment she wanted.

<sup>3</sup>The mechanism for this classification has not been validated. Accordingly, the judgments should be considered as impressionistic.

<sup>4</sup>Freidson includes "folk healers" in this lay referral structure.

<sup>5</sup>Cosmopolitan patients may be particularly sensitive to the opinions of their immediate social group because their lay referral system is restricted (cf. p. 20).

<sup>6</sup>As discussed in Chapter 7, Healer IV in fact was tremendously conflicted about the place of his ego in his healing. He believed it should have no place. Actually, it seemed omnipresent. Patient IVd is one of his assistants, a person who knows Mr. Grasso very well. Could she possibly wonder sometimes if he is a quack?

<sup>7</sup>Two other groups of patients are not considered here because their expectations of the healer-patient sharing of responsibilities were not critical factors in their use of unorthodox care. One group assumed sharing of responsibility and did not point to this aspect of their relationship with a healer as an important factor in their behavior. The other group, regardless of the patients' healing philosophies, actually expected to depend on the healer.

<sup>8</sup>Participation in decision making is of course distinguishable from participation in the treatment process. A surgeon may allow a patient full participation in decision making about an operation through the conscientious use of informed consent procedures. These 14 patients not only wanted to share in decision making, but also in the therapeutic process itself, e.g. through praying, thinking positive thoughts, yoga, diet, etc. As pointed out in Chapter 10, the type of therapy used by a healer necessarily affects the kind of relationship s/he will have with patients.

<sup>9</sup>Many of the patients, especially those of Healers I, III, and IV, would probably not agree that these were "chance" events. For these people, there was no such thing as a coincident.

## CHAPTER 11

### REFERENCES

A study of Motivational, Attitudinal and Environmental Deterrents to the Taking of Physical Examinations that Include Cancer Tests. New York, Lieberman Research, Inc., (sponsored by the American Cancer Society), 1966

Festinger L, Riecker HW, Schacter S: When Prophecy Fails. Minneapolis University of Minnesota Press, 1956

Freidson E: Client control and medical practice. Amer J. Sociol 65: 374-382, 1960

Kasl SV: The health belief model and behavior related to chronic illness. Health Educ Monog 2: 433-454, 1974

McGorkle T: Chiropractic: a deviant theory of disease and treatment in contemporary western culture. Human organization 20: 20-23, Spring 1961

Scott CS: Competing health care systems in an inner city area. Human Organization 34: 1, 105-110, 1975

Suchman EA: Social patterns of illness and medical care. J Hlth Human Behav 6: 2-16, 1965

Zbrowski M: Cultural components in response to pain. J Soc Iss 8: 16-30, 1952

Zola IK: Studying the decision to see a doctor. Adv Psychosom Med 8: 216-236, 1972

SECTION V

DISCUSSION AND CALL FOR RESEARCH

## CHAPTER 12

### LIMITATIONS OF THE DATA

Before analyzing the data, their limitations must be recognized. Seven factors are of concern: my personal biases, the sampling technique, small samples, reliance on the patients' retrospective reporting, subjective measures, theoretically relevant areas not studied, and editing of the data.

My prejudices regarding the phenomena under investigation may have influenced the collection, reporting and interpretation of patient histories. These biases should be made clear. Before making the decision to research unorthodox illness behavior, I was thoroughly naive about the existence of alternative forms of healing in Greater Erehwon. I assumed that, excepting for a few chiropractors and perhaps some healers indigenous to the lower class hispanic community, "folk healers" in the United States were largely confined to the deep south. An hour in an expensive health food store in New Erehwon upset this preconception as I heard a salesperson prescribe herbal remedies and diets for specific medical problems. Preliminary investigations raised further suspicions that Greater Erehwon might be the site of a great deal of alternative healing activities for the middle and upper class. Antedating the formulation of the research and the formal collection of data, I therefore suspected that:

- (1) The use of unorthodox healers is not confined to parochial, medically unsophisticated, and/or desparate people.
- (2) People in social classes I-III choose unorthodox care because (a) they seek greater control of their health care; (b) they are opposed to pharmacologic

and surgical intervention; (c) they wish to avoid repeating negative experiences they have had with medical doctors; or (d) they seek more efficacious treatments.

In order to at least partially control for the effect of these biases on my subjects reporting (demand characteristics), all observations and collection of verbal information were done, as much as possible, without any suggestive intervention on my part. During observations, I attempted to remain unobtrusive. Interviews were structured so that, except for guiding the discussion into the topic areas outlined by the questions in Appendices D and G, subjects were encouraged to talk spontaneously about themselves, and their illness and healing experiences.

Sampling of both healers and patients was purposive. Healers and their patients were selected for study according to the criteria listed on pages 31,33. Since healers selected the patients to recommend for interview, the healers biases may have affected the type of patients studied.<sup>1</sup> Healers might be expected to have suggested their most satisfied patients and perhaps those who were most like the healers themselves. Further both the size of the healer sample (5) and the patient sample (25) are small. Each of the 5 patient sub-samples contained only 5 patients.

A third limitation of the data is a function of the research design. All information was collected by observation and interview from (for the most part) the subjects themselves. These personal interactions undoubtedly were laden with the demand characteristics

shaped by my biases (see above). Further, most of the information gathered depended on the verbal reports of the subjects. Ideas, as well as information such as medical diagnoses, may not have been accurately communicated. Other information may have been purposely, or unconsciously, concealed or distorted by the subjects. Even more confounding, much of the reporting, particularly by the patient subjects, was retrospective. Memories are fallible. Further, because beliefs and attitudes are known to be affected by behavior, there can be no assurance that they were not the result of, rather than the cause of, behavioral decisions. Finally, no attempt was made to corroborate the information obtained with other sources, eg. people or records.

The few measures used in this study, medical knowledgeability and medical orientation, are largely subjective and validated only on face value. Except for the data concerning the patients' knowledge of the warning symptoms of cancer, they must be considered impressionistic.

A fifth limitation of the data is also a function of the research design. Two areas that are probably of great relevance to the understanding of illness behavior were not adequately studied because of practical considerations. Janis (1968) has hypothesized that unconscious factors affect most decisional processes. Although some analytical inferences have been made in presenting the interview material, no attempt was made to gather the type of information that would be necessary for an in-depth consideration of psycho-

dynamic factors affecting patient behavior. In any case, there are many investigators (Skinner 1978) who would disagree with Janis in the relevance of unconscious factors in behavioral determination. Fink (1969) and others (Pratt 1976) suggested that family structure may be a more influential intervening variable in illness behavior than such factors as age, sex, ethnic group, and socio-economic status. Janis (1968) emphasized the impact of the group dynamics of a person's immediate social context on decision making. In my study, some information was gathered about a person's social group and the influence that it had on facilitating and/or influencing a patient's behavioral decisions. Most of this data, however, was collected from the patients themselves. Further, data collection in this area was limited by the time constraints of the interviews.

Finally, a great deal of potentially useful data has been collected and not reported, eg. religious practices of patients, health habits, personality assessments, or only selectively reported, eg. illness beliefs of patients. Editorial judgments were made in view of the main purpose of generating ideas about unorthodox illness behavior. The reader must beware however, of the possible effect of my editorial biases.

Given the limitations of the data, how can it be used? Statistical analysis, other than reporting numbers of case examples, has no place in the discussion of the findings because of the limitations. The subjective methods of this thesis reflect its purpose.

No generalizations from the findings can be made. Rather, they are to be used as a source of ideas relevant to the understanding of unorthodox illness behavior. These ideas may be tested in future research. The most important concern about the biases operative in this study is that they may have obscured certain critical factors relevant to a grasp of the complexities of the decision to seek unorthodox care. Secondarily, I would hope that the patient data is descriptively accurate. That the data do not always mirror, and in fact, sometimes strongly conflict with the beliefs of the interviewer and the patient's healer, suggests less bias than expected.

CHAPTER 13

ON CHOOSING A HEALER: DISCUSSION AND IMPLICATIONS

A great deal of information about healers and their middle and upper class patients has been presented. Throughout the presentation, issues and variables related to the decision of a patient to seek unorthodox health care have been pointed out. The purpose of this chapter is to review salient ideas emerging from the field study, with reference to existing illness behavior literature. Specific variables and general issues which have been found to be relevant to the sample patients' behavior are pointed out as important considerations in the formulation of general models of illness behavior. To conclude, areas where further research is necessary are indicated.

#### THERE IS A CHOICE

The most obvious theme of this thesis has been that orthodox medical doctors are not the only available health consultants in Greater Erewhon. Beyond whatever friends or family a person may choose to ask for advice, a vast array of alternative health practitioners exist. Few models of illness behavior take this empirical fact into consideration (Anderson 1973, Fabrega 1974). Their point of focus is simply predicting when and why a person will utilize a professional health service (Becker 1974, Kirscht 1974, Rosenstock 1966). This perspective is analogous to presuming that one understands a person's eating behavior because one has developed a model predicting when a person will go food shopping. Two people going to the supermarket might come home with very different types of

food - so too, may two people who have decided they need health care.

The field study has shown that not only may one person go to the store for meat and another person for potatoes, but that usually they both go for more than one item. Also, they may shop at different stores (healing philosophies). Virtually all of the patient sample used a health practitioner from at least two different healing categories for their present illness. Clearly, a complete explanation of a person's illness behavior must recognize that people do not simply decide whether symptoms require health care, they also choose what kind of health care will meet their needs at the moment.

#### HIERARCHY OF RESORT

Illness is not a discrete event. A study of the sample patients' illness experiences has confirmed what seems like an obvious point - illness is a process occurring in stages. As a person goes through the various stages of an illness, s/he follows a career of seeking help from different sources with multiple decision points along the way (Fabrega 1974, Freidson 1961, Zola 1973). As introduced in Chapter 2, this career reflects a hierarchy of sources of care with different alternatives being used as an illness progresses and depending on their place in the hierarchy. Examples provided of patients' illness experiences support the idea of a person's needs evolving during the course of an illness. To the extent that a doctor or healer could not meet these changing needs, the person

consulted another source of health care. Additionally, multiple sources were used at any one point in time for multiple needs.

With few exceptions (Fabrega 1974, Janis 1968), illness behavior models assume discrete states of health and illness. In doing so, these models incorporate neither the processual concept of illness stages associated with multiple sources of health care, nor the effect of a patient's interaction with the care providers.

Ascertaining factors determining the order in which a person utilizes health consultants, i.e. why a patient chooses to consult a given healer at a particular point in time, was a major focus of the field study. Beyond understanding the course of a person's illness, a number of other variables, discussed below, were found to be relevant to a person's decisions.

#### THE HEALER

Many of the sample patients' choice of health care was strongly influenced by past experiences with healers and/or doctors, and by their expectations of what a healer would offer. Although some students of utilization behavior have looked at attributes of physicians or the organization of care (McKinlay 1972, Fabrega 1974), most comprehensive models of illness behavior neglect the impact of the doctor (healer)-patient relationship (Kasl 1974). This exclusion is surprising because of the voluminous literature documenting the effect of this interaction (Francis 1969, Freidson 1961, Kasl 1974, Koos 1954, Korsch 1968). One investigator, Anderson (1973), interested

in a patient's decisions about what medical paths to take, found that a key determinant of the choice was the person's appraisal of the services provided by various health service options.

An extensive investigation of who patients could choose for unorthodox health care in Greater Erehwon has been presented in Sections II and III. Key factors differentiating the healers available to patients are discussed here: personal qualities, healing philosophies, type of healer-patient relationships, conceptions of illness and healing, therapeutic techniques, and organization of practice.

#### Personal Qualities of Healer

The sample patients were similar to most people surveyed (Koos 1954, Freidson 1961) in that they looked for certain agreeable personal characteristics in their doctors and healers. After a number of bad experiences, some patients assumed that all doctors were personally disagreeable and resorted to unorthodox care. At the time of interview, all of the patients were extremely satisfied by their personal relationships with their healers. More relevant to the differentiation of healers from doctors and of one healer from another were the "special" personal attributes of a healer. As reviewed in Chapter 10, many unorthodox healers, in categories I-IV are characterized by their perception that they have a healing presence. They offer their patients not so much a particular

therapeutic technique as a healing "energy." These healers are distinguishable primarily on the basis of their definition of, and mode of implementing, this energy. Many patients were found to specifically seek unorthodox healers for these special qualities. The need for these special and, if you will, mundane, qualities in a healer emerged during the course of an illness and in part determined when and who a patient would consult.

#### Healing Philosophies

The major distinctions made between healers in this study has been on the basis of their healing philosophies. By the classification scheme used in this study, patients had seven options to choose from. The options were primarily distinguished on the basis of the relative responsibility of a higher power, healer and patient (○ □ △). A theory has been proposed which relates a healer's philosophy to his/her behavior with patients. In the first place, a healer's philosophy was seen to be associated with the presence or absence of special personal qualities of healers. Secondly, healing philosophies were shown to be rough predictors of the locus of control in a healer-patient relationship. Four major factors were observed to affect the translation of the study healer's philosophies into their actual practices: personalities of healers and patients, type and stage of medical problem, position of healer in the patient's referral structure, and socio-cultural variables.

### Type of Healer-Patient Relationships

Whether or not healing philosophies were linked to type of healer-patient relationship, healers were clearly distinguished on the basis of their role relative to patients. Three kinds of interactions were described as available to patients: healer in control (   ), healer and patient equally sharing of power (   ), and patient in control (   ).

### Conceptions of Illness and Healing

A broad spectrum of conceptions of illness and healing, correlated with the spectrum of healing philosophies, is represented by the healers in Greater Erehwon. The 5 healers studied intensively range from a basically pseudo-scientific medical-type model of illness, treatment and cure (Ms. Kirbo) to more metaphysical conceptions (Mr. Carbonella). The lower numbered the healer, the more likely that a healer's conception of healing differed from the medical definition of cure. Thus Mr. Carbonella (I) believed that a person could be healed without necessarily affecting the disease process itself. Healing and illness for him was a function of a relationship with a higher power. The more dramatically distinct a healer's conception of healing and illness was from that of scientific medicine's, i.e. the lower numbered the healer, the less a healer tended to be antagonistic toward orthodox medicine. Broadly speaking, the same generalization holds for physician's attitudes toward healers.

### Therapeutic Techniques

Healers offered patients a wide variety of diagnostic and therapeutic techniques not available from an orthodox doctor. Although similar techniques might be used by healers of many different healing philosophies, eg. laying on of hands, a tendency exists for less invasive techniques to be used by lower numbered healers. The type of therapeutic technique used has some bearing on the healer-patient relationship, eg. the intravenous injection of Laetrile intrinsically creates more dependency than teaching Yogic exercises.

### Organization of Practice

The different types of organization of healers' practices in Greater Erehwon were reflected in the sample of 5 healers studied. The following modes of practices were used: hospital practice (Mr. Carbonella), therapeutic community (Dev Singh), office practice (Mr. Grasso, Dr. Lowkap, Ms. Kirbo, and Dev Singh), residential care (Ms. Kirbo, Dev Singh) group practice (Ms. Kirbo with psychic healers), house calls (Mr. Carbonella, Mr. Grasso, Dr. Lowkap) and phone calls (Mr. Carbonella, Dev Singh, Mr. Grasso, Dr. Lowkap, and Ms. Kirbo). Undoubtedly, these various modes of practice affected patients' choices of healers. Indeed, Mr. Carbonella's mode of practice was similar to the hospital-based tertiary care specialist. In general, either he chose his patients or a patient was referred to him by another professional care giver. Participation in Dev Singh's therapeutic community required a major behavioral change by patients.

Ms. Kirbo's group practice made a patient's consultation of her in tandem with her psychic healer partners more likely than if the healers were practicing independently.

#### REFERRAL STRUCTURE

There were two major reasons to investigate the healers: to learn how the healers' beliefs and behavior affected their patients and to learn what was available to patients seeking unorthodox care. Regarding the latter point, it would be unwarranted to assume that all patients were well-informed in their choices of health care.<sup>1</sup> Or, that given this information, they made utilitarian decisions. This section reviews the study findings relevant to the issue of informed choice. Three types of systems are identified by which a sample patient may have chosen a healer: lay referral, professional referral, and chance referral (intuitive knowledge).

##### Lay Referral Structure

Freidson's (1960) concept of a network of lay consultants was first introduced in Chapter 2. Here it is mentioned to illustrate one way in which the sample patients learned about healers. Freidson assumed that the lay referral structure is truncated when the lay culture and the professional culture is as similar as in the case of the sample patients. In this case, he suggests that the "prospective client is pretty much on his own, guided more or less by cultural understandings and his own experience, with few lay consultants to support or discourage his search for help."

In a sense, Freidson's expectations were fulfilled by the sample patients. Beyond a person's immediate social group, most personal contacts of the patient, as well as his/her broader social group, were ignorant of and/or hostile to alternative ways of healing. Similarly, the patients' cultural background was not supportive of unorthodox illness behavior.<sup>2</sup> The patients were indeed forced to rely on their own experience along with the people in their immediate social context. From the collective experience of these few people, however, the patients gained considerable support for and/or information that influenced their decision making. Thus it was pointed out that over half of the patient group had resorted to unorthodox health care for other than their present illness. Many of the patients added to the knowledge gained about healers from this personal experience by reading about unorthodox therapeutic techniques. Close friends and family not only supported patients' unorthodox illness behavior, but also referred them to particular healers with whom the friends or family had had experience.

An additional mechanism by which a few of the patients informed themselves was by using many of the techniques I used in collecting data about healers in Greater Erehwon, i.e. they frequented health food stores or public meetings concerning unorthodox health care or read newspaper articles about particular healers or healing techniques.

It should also be pointed out that a few of the patients were extremely knowledgeable about their various options. Understandably, these people were primarily those whose search for health had been protracted or who were members of a social group, eg. the BHO ashram, which was committed to the use of alternative forms of healing.

It has also been shown that, in general, the patient sample was relatively well-informed about selected areas of scientific medicine. Indeed, some patients were themselves or had close family members who were health professionals. One would be hard put to count these patients' choice of unorthodox care as due to their ignorance of appropriate illness behavior. In fact, several patients who were particularly well-informed about the medical implications and treatment of their diseases, specifically wanted either to reject orthodox medicine or use it in concert with another method.

In one other sense, Friedson's (1960) description of the lay referral structure of cosmopolitan people was only partially applicable to the sample patients. With few exceptions,<sup>3</sup> these patients did not consult the local folk healer on the corner. Generally, without significant delay, the patients first resorted to orthodox physicians. What Friedson's theory fails to explicitly acknowledge is what happens after the medical professional has been consulted. In the case of the sample patients, they then resorted to alternative forms of healing. Further, they sought care from healers whose social background was in general markedly different

from the patients. Hence, theorists who make generalizations about the illness behavior of "cosmopolitan" patients' illness behavior on the basis of their initial choice of health care - usually a medical professional - may be missing significant aspects of these patients' behavior.

#### Professional Referral Structure

Freidson (1960) limited the concept of a professional referral structure to the people that a medical doctor might refer a patient to. The key difference between the professional and lay referral structures in Freidson's eyes was that in the former, choices of care are made by physicians according to their perceptions of the needs of the patient, whereas in the latter structure, the choices are made by the patient on the basis of his/her perception of need. In the former case, the patient generally depends on the professional's knowledge about the doctor to whom the patient is referred. In the latter case, the patient's own knowledge, as gathered from past experiences and friends is the principal resource for decision making.

In several cases, sample patients have been shown to consult healers on the basis of what is best called a professional referral system. For example, all of Mr. Carbonella's patients' contact with him was initiated through such a system.<sup>4</sup> Some were contacted by Mr. Carbonella directly in the manner of an intern assigned to a particular hospital ward. Others were referred to Mr. Carbonella by other helping professionals, eg. nurses or chaplains. Similarly,

Ms. Kirbo would often refer patients to her psychic healing partners and vice versa. In these cases, the patients were dependent on "professional" opinions rather than in the patient's personal knowledge of a source of health care.

#### Intuitive Knowledge and Chance Referral

Most health decision-making models assume that decision-making is rational - or at least that the decision-maker behaves as if in response to a utilitarian consideration of alternative choices (Rosenstock 1966, Fabrega 1974). At least one investigator, Janis (1968), has emphasized the role that non-rational factors may play in decision making. Examples of the impact of intuitive factors in patients' interpretation of, and behavior in response to, symptoms have been presented. Further, without knowledge of a healer beyond his/her healing philosophy and techniques, some patients' utilization of a particular healer was seen to be more a function of chance than of an informed decision.<sup>5</sup>

#### THE PATIENTS

This section reviews salient characteristics of the patients to bring further insight to why they chose unorthodox care. Some of the findings are at variance with the predictions of illness behavior theorists or my own expectations. Further, some variables and issues are considered which are not included in extant models of illness behavior.

### Social Characteristics

Most of the literature would not have predicted on the basis of the sample patients' social characteristics alone that the patients would have resorted to unorthodox health care. (Freidson 1960, Koos 1954, Suchman 1965). There are three possible resolutions to this apparent conflict. First, factors other than the patients' broader socio-cultural context were more influential in determining a patient's source of care. Many of these factors are discussed in other sections below. An additional consideration, i.e. the influence of a patient's immediate social context has already been discussed above.

A second possibility is that certain aspects of the patients' broader social group are in fact currently supportive of unorthodox illness behavior. Against this possibility must be placed the observation that most of the patients purposely concealed their use of alternative healers for fear of the opprobrium of the patients' peers. On the other hand, considerable circumstantial evidence, as presented in Chapter 2, suggests that "unorthodox" ways of healing are becoming increasingly acceptable in middle and upper class society. If my impressions of this groundswell are accurate, the use of alternative healers may not represent the kind of renegade behavior it would have for these patients 10 or 20 years ago when Freidson, Koos, Suchman and others were doing their work.

The third possibility is that previous researchers were simply wrong. As discussed on p. 308, they may have based their generalizations

on only one aspect of cosmopolitan illness behavior - the initial professional consultation.

#### Medical Orientation

The measures used to ascertain the patients' medical orientation were admittedly not identical to those used by Suchman (1965). Nonetheless, they are roughly comparable for the purposes of this discussion. By my measurement, about one half of the patient sample was positively inclined to use scientific medicine and yet all utilized unorthodox care. Although 7 patients were strongly anti-medicine at the time of the interview, virtually all of the patients initially used orthodox medicine for their present illness. Medical orientation was, however, well associated with concurrent use of healer and physician. No patient who was strongly anti-medicine continued consulting a physician. My findings may be confounded by the retrospective nature of the data collection. Nevertheless, again, these results confirm the point made previously that a theory of illness behavior must consider what a patient does after s/he has first consulted the physician.

#### Illness and Healing Beliefs

The field study has demonstrated a remarkable congruence between the patients' healing philosophies and those of their current primary unorthodox healer. Two questions arise concerning this similarity: (1) are the beliefs reported by the patient at the time of interview primarily the cause or the effect of a patient's

illness behavior and (2) is the patient's choice of a healer related to the patient's desire for a particular role in his or her treatment.

Rosenstock (1966, 1974), Kirscht (1974), Becker (1974) and Kasl (1974) have reviewed the evidence for the applicability of the Health Belief Model respectively to health, illness, sick-role and at-risk behavior. In summary, the evidence is suggestive that health beliefs do mediate the relationship between socio-structural characteristics and health/illness decisions. Unfortunately, the research supportive of these conclusions is subject to a number of methodological criticisms. In particular, the findings have been all too often inconsistent in direction and strength (Kirscht 1974). Little is known about their stability or the reliability of their measures. Furthermore, retrospective studies cannot be used to test the hypothesis that a particular constellation of beliefs determines a subsequent behavior. Work with the knowledge-attitude-practice paradigm of health education and with cognitive dissonance has shown that behavior, which is perceived as freely-willed, modifies beliefs (Festinger 1957). The implications for health/illness behavior is that uncoerced behavioral decisions regarding health services may alter a person's beliefs related to these actions. Indeed, prospective studies have often revealed a wide gap between people's beliefs about what kinds of health/illness actions they should take and those that they actually perform (Feldman 1966, Young 1967).

With these considerations in mind, a number of points arise

in attempting to explain the similarity between the healers' and patients' beliefs. The simplest explanation is that the patients' beliefs, among other factors, prompted them to select a healer with similar beliefs. Examination of patients' utilization behavior, however, has revealed that patients have used health care providers with different healing philosophies. Freidson (1960) stated that "In so far as the idea of diagnostic authority is based on assumed hereditary or divine gifts or intrinsically personal knowledge of one's 'own' health necessary for effective treatment, (medical) professional authority is unlikely to be recognized at all." Numerous examples from the patient sample have been cited to document that although a person may have, at the time of interview, substantially different healing and illness beliefs than a medical doctor, the patient will usually first consult the physician. Schwartz (1969) proposes an appealing resolution to this apparent conflict. He, too, found that a person's choice of care reflected a person's conception of his/her disease and the process of healing. Importantly, however, whenever a healing system's treatment was known to be quickly effective, dramatic and evident, it prevailed over others. At the time of the original orthodox consultation, the expectations of the sample patients for scientific medicine were probably that it had a quick and effective cure for their conditions. When their conditions proved refractory to medical care, the patients sought unorthodox methods - again in the hope for a quick and effective cure. The question remains, however, whether belief in the efficacy of a

particular treatment affects a person's whole constellation of healing and illness beliefs.

With some modifications, Schwartz' reasoning applies to the patient sample. One exception is that at least some of the patients, eg. Vb, were so strongly convinced of the risks of orthodox treatments, no matter how efficacious, that these patients preferred natural, more slowly acting methods. Second, a large number of patients used orthodox care in tandem with an alternative healing art. These patients clearly distinguished between medical treatments (curing a disease) and healing (a process affecting the whole person).

Another consideration is that patient beliefs may have changed over time. They may have evolved during a person's illness career either due to the impact of the illness itself or to the actions taken during the illness. The effect of an illness may make a person question his/her beliefs about illness and healing. For example, several patients were quoted who have come to accept that they will always live with their disease. Rather than looking for a "cure" these people have begun a search for healing. Other patients with enduring medical problems have begun to believe that a higher power must have some purpose in giving them an illness. Somehow a chronic, meaningless illness was worse for these people than one that had some metaphysical justification. As a patient's beliefs changed during an illness, s/he may be motivated to seek healers of similar philosophies.

Finally, the patients may have "learned" their beliefs. In this case, the beliefs cannot be considered as causal factors in the patients' illness behavior. The beliefs may have changed as a result of their various health choices. Perhaps the efficacy of a treatment reinforced a patient to conceptualize illness and healing in a manner similar to the healers who successfully treated the patient. Or, to reduce cognitive dissonance, the patient may begin believing what s/he is doing. Some patients may literally have been taught what to believe, eg. the 3HO ashramites and the patients of Mr. Grasso who participated in his psychic development classes. Also to be considered is that, as noted in Chapter 12, the patients may have responded to the demand characteristics of the interview setting.

#### The Healer-Patient Interaction

The doctor-patient relationship has been shown to affect the compliance and utilization behavior of the patient (Fink 1969, Francis 1969, Korsch 1968). The quality of this relationship has for at least two decades been one of American's major complaints about orthodox medicine (Koos 1954, Freidson 1961, Kasl 1974). In light of this empirical knowledge it is surprising that there has been little attempt to incorporate the effect of the healer (doctor)-patient relationship in models of illness (sick-role) behavior.

In the field study three broad areas of the healer-patient interaction were found to be relevant to the patients' illness

behavior: personal qualities of the healer, explanations of illness, and patient role in the interaction with healer. The first two areas have been adequately discussed (pages 263-8). This section is reserved for more thorough review of the third area - the role of the patient.

#### The Patient Role

As pointed out in Chapter 2, there is apparently a groundswell of public interest, particularly among the middle and upper class, in gaining more control over their health care (Levin 1976). Over half of the sample patients were found to specifically seek unorthodox care for a more active role in their relationships with healers. A theory has been presented (Chapter 10) which yields insight into how a patient might choose a source of health care in order to maximize the possibility of achieving greater control. By selecting a healer of a particular healing philosophy a patient may expect a certain type of relationship with his/her healer.

There are two other factors which may support a patient's expectations of achieving control of their health care. First, patients may be aware that by choosing a healer, they are selecting a person who intrinsically has less social authority than a physician, for both socio-economic and cultural reasons. Second, the very act of choosing a healer affords the patient a measure of control. Once within the professional referral system, the patient abdicates this aspect of control. A patient's personality was also seen to

modify the type of relationship they actually had with healers. The mother of patient IVa, for example, was able to maintain some control of her child's health care, even with orthodox physicians because of her assertive personality.

For different types of problems, or during different stages of a given disease process, a patient has different personal needs (Suchman 1965, Szasz 1956). Parson's (1951) model of the patient adopting a dependent position in the sick role is becoming increasingly less relevant as the burden of morbidity in the United States shifts from acute to chronic or "at-risk" problems (Kasl 1974). Kasl points out the need for a re-formulation of the concept of patient role to take high risk states and chronic diseases into account. Szasz (1956) has argued that if a patient's relationship with his/her healer (doctor) does not change with the evolving needs of a patient throughout the different stages of a disease process, the interaction may be terminated. In fact, several sample patients were shown to seek unorthodox care because their physicians were not flexible to the changing needs of patients. Sample patients were also seen to switch healers for similar reasons. Patient VIId, for example, first sought help from an orthodox physician for menstrual problems. The gynecologist did not allow her a sense of control in the relationship or treatment process. Still acutely troubled, she then sought unorthodox care from a Technical healer, Ms. Kirbo. Although Ms. Kirbo's modal relationship with patients was [redacted] ▲, the patient nonetheless gained some

measure of control, because Ms. Kirbo was within the patient's lay referral structure. Finally as the patient's illness subsided, she switched her primary relationship with a healer to one in the spiritual category, (Ms. Kirbo's psychic assistant) where patients are generally allowed more control.

In sum, the role a patient expected to play, in a relationship with a doctor/healer was seen to strongly influence the patient's choice of unorthodox care. These expectations were also intimately linked with the decision to use a healer of a particular philosophy. A patient's choice of a healer from a given philosophical category may, then, reflect the patient's need for a certain type of healing relationship.

#### Past Illness Experiences and Behavior

Most illness behavior models consider the impact of past illness experiences and behavior on present illness behavior. The field study identified three aspects of a patient's past experiences that were germane to current unorthodox behavior: past medical history, satisfaction with past medical interactions, and past experiences with healers.

#### Aspects of the Illness Experience

Scientific medicine is founded on specific etiologic diagnosis and therapy. Virtually all of the sample patients carried a specific medical diagnosis. Most of them have, at one time, been treated by

an orthodox method. The critical question remains as to why the patients initiated and continued the help seeking process.

As noted in Chapter 2, the illness behavior literature has exhaustively documented that, in general, symptoms per se are not what differentiates patients from non-patients. Rather, it is the psycho-social and cultural meaning that a symptom has that more closely determines whether a person will seek professional help. Some of the many factors which contribute to this meaning have been discussed in this thesis, eg. past medical history, health beliefs, etc. The point to be made here is that a patient does not so much bring a symptom to a health provider as a complaint. Modell (1961) makes this distinction clear:

...while there is a close and continuous connection between the symptom and the complaint made by the patient, the latter is not merely a verbalization of the former, but is the culmination of the effects of a set of forces which determine when the patient will feel impelled to complain of the symptom to his physician. The symptom is a reaction to disturbance; the complaint is a communication about the distress caused by the reaction, and it is made when it has achieved for the particular patient sufficient intensity to warrant a request for help by him.

Table 111 illustrates the distinction between the sample patient's diseases, symptoms and complaints. As pointed out in the discussion of this table, many of the patients' physicians were more attuned to the patients' diseases than their complaints. Indeed, most of the patients told me that they never successfully communicated their complaints to their physicians. Modell (1961) describes what he feels to be the impact that the healer-patient interaction can

have on the patient's complaint. Further, he states that the patient's choice of a particular healer reflects the nature of the complaint to be made.

The patient's choice of particular physician, when choice is possible (i.e. when not in a professional referral system), bears on the nature of the complaint he will make. By this I mean, first, the obvious fact that the attitude of the particular physician can affect the patient's communication, that he can direct it or encourage it or inhibit it. I also believe, however, that the type of healer and the personality of the healer the patient chooses can subtly indicate the kind of ...relief the patient has chosen for himself, to which he will be responsive or which he may, in fact, need.

To have their complaints heard and alleviated, many of the sample patients resorted to an unorthodox healer. The sample healers in general (probably excepting Ms. Kirbo), were more interested in their patients' illnesses than their diseases.

Illness is a term which can be reserved to describe how a person is affected by a disease (Dubos 1965, Fabrega 1974). The word disease can be limited to the scientific taxonomic description of the pathophysiology process. The understanding of the behavior of a person who has a particular disease or symptom is furthered by looking more broadly at their illness. A person's complaints are a reflection of their illness. Most often of course, disease and illness are intimately connected, eg. the woman who is crippled with a vertebral collapse and is worried that she cannot care for her children. Sometimes, however, the "illness" has little to do with the disease, eg. the man who presents with a cold to the doctor, but is most concerned about his job.

And often, the major complaint, whether it be conscious or unconscious, is never voiced.

The distinction made here between disease, symptom and complaint is not to say that these patients were uninterested in cure or relief of symptoms. On the contrary, the point is that the patients had multiple needs. Certainly they sought cure and relief of symptoms where possible. And certainly they sought attention for the effect that the disease and symptoms had had on their lives. Whenever a particular health provider was unable to meet all of these demands, the patient was predisposed to seek additional help. Further, to the extent that a care giver was unable to respond to the changing needs of a person during the course of an illness, the patient was inclined to look elsewhere for assistance.

#### FOR FURTHER CONSIDERATION

There are two aspects to the help-seeking career of a patient: (1) the decision whether symptoms need a healer's (doctor's) attentions and (2) the decision about what source of health care to use at a given point in time. This study has been primarily concerned with examining the latter decision. In particular, the focus has been on the decision of middle and upper class people to use unorthodox health care. This investigation has only broken the ground. In the process, it has stirred up a number of possibly fertile ideas for further theoretical and empirical study. I conclude then with an outline of the most salient considerations for further research which have emerged from my work.

## 1. Utilization behavior

My preliminary work has documented the existence of a large number of alternative healers in a sample metropolitan area. Data collected is suggestive that a large number of middle and upper class people use these resources. Several questions remain to be statistically confirmed.

- a) What is the utilization rate of the various types of healers by middle and upper class people?
- b) Is this utilization rate increasing over time?
- c) What place do these healers serve in their patients' hierarchies of resort? What determines their ordering?

## 2. Determinants of the choice of unorthodox care

A number of factors have been isolated as associated with the choice of unorthodox care. Some of these apparently influence the choice of a particular type of healer. Further research is needed to determine if these associations are statistically valid and if they are independent or dependent variables. The identified variables, as well as general related research questions are listed below.

- a) Socio-demographic Factors.
  - i. To what extent can socio-demographic factors distinguish people who seek unorthodox care from those who do not? Preliminary evidence suggests that the use of unorthodox care is not restricted to lower class or minority people.
  - ii. Is the mainstream American culture becoming more tolerant and even supportive of alternative forms of healing?
  - iii. What is the impact of a patient's immediate social context on his/her choice of care? The field study suggests that the unorthodox patient's immediate social group is supportive and/or influential in his/her decision to seek unorthodox care.

## b) Medical Orientation

- i. What is the effect of medical orientation?
- ii. Does it perhaps order a person's hierarchy of resort?

## c) Medical Knowledgeability

A rough impression of the sample patients' knowledge of scientific medicine suggest that they are more informed than the average American. Traditionally it has been thought that uninformed patients are among the more frequent utilizers of unorthodox care. This preliminary finding suggests that at least some people are making informed choices of unorthodox care.

- i. A more accurate measurement of unorthodox patients' medical knowledgeability is needed.
- ii. Does medical knowledgeability distinguish orthodox from unorthodox patients?

## d) Illness and Healing Beliefs

Sample patients' and healers' illness and healing beliefs were remarkably congruent.

- i. Prospective studies are needed to determine whether patients' beliefs antedate or post-date their unorthodox behavior and whether they change during the course of an illness.
- ii. How influential are a patient's beliefs in determining his/her choice of health care given other considerations eg. type and stage of illness.

## e) Past Illness Experiences and Behavior

These variables are apparently strongly related to patients' choice of unorthodox care. Corroborating statistically valid evidence is necessary.

- i. To what extent does a patient's satisfaction with past medical and/or alternative healing experiences influence their present behavior?
- ii. How important is a patient's past medical history in determining the source of care that a patient desires?

f) Healer-Patient Interaction

Three aspects of the healer-patient interaction have been proposed as determinants of a patient's choice of health care. A healer's healing philosophy has been suggested as affecting all three aspects of this interaction. The following questions are based on the suggestive evidence of the field study.

- i. To what extent does a patient's expectation of certain personal qualities in a healer determine their choice of healer? Does a person choose a healer of a particular healing philosophy with the expectation of the healer having certain "special" qualities?
- ii. To what extent does the patient choose a healer for particular types of explanations of illness, eg. metaphysical explanations, scientific explanations.
- iii. To what extent do patients want greater participation in their health care? How is this desire linked with types and stages of medical problems? Does a patient's desire for greater participation influence his/her choice of health care?
- iv. How does a healer's healing philosophy affect these three aspects of his/her relationship with a patient? What else influences this relationship? Do patients choose healers of particular healing philosophies with the expectation of certain types of relationships with healers?

g) The Informed Patient

How informed are patients' decisions about choice of health care? What are their sources of information?

h) The Illness Experience

- i. How important is a patient's main worries in determining their choice of health care?
- ii. How is a patient's hierarchy of resort linked with the course of their illness?

## i) Intuitive Factors and Chance Referral

- i. What is the importance of non-rational factors such as chance dreams, visions, etc. in initiating the process of seeking health care?
- ii. How do these factors influence the choice of particular pathways of help-seeking?

## j) Efficacy and Risks of Unorthodox and Orthodox Treatments

Many of the sample patients chose unorthodox health care because of their perception of the superior efficacy and harmlessness of unorthodox healing methods. I have not reported on these factors except to present patient perceptions. Clearly, further research is indicated to explore the clinical usefulness of the more promising unorthodox methods.

## DOCTORS AND HEALERS

Virtually all of the sample patients used both orthodox and unorthodox care. Unquestionably, the use of multiple sources of care must affect the way a patient follows the recommendations of each provider. Inevitably, there is some impact on the patient's health. At least according to the patients, few physicians knew of their patients' unorthodox activities. Nor is there substantial information available in the literature about middle and upper class patients' use of unorthodox care. Hopefully this study will serve to both inform and open new avenues of research. The knowledge to be gained is too important, however, to be restricted to the social scientists. Patients' help-seeking behavior says a lot about illness. In their daily contact with patients, doctors have a rich opportunity to learn about what patients want and do when they are sick.

## SECTION V FOOTNOTES

### Chapter 12

<sup>1</sup>Only 2 patients so recommended were not included in the study. One patient refused participation. He was a 25 year old white male, reportedly with Stage IV Hodgkins disease, whose experience with orthodox medicine had so embittered him that he felt that rehashing these experiences would interfere with his healing. He was an in-patient of Ms. Kirbo's. The other patient, an elderly white woman, was from Dr. Lowkap's practice. I rejected her because she lived too far from New Erehwon to make interviewing practical.

### Chapter 13

<sup>1</sup>During the time of my preliminary investigations of healing in the Greater Erehwon Area, notices and advertisements were used to request information about healers (Appendix A). As many people called me wanting, as giving, information. Parenthetically, the number of calls of the former type provided further circumstantial evidence that consultation of unorthodox healers was not an unusual practice.

<sup>2</sup>Nonetheless as pointed out on p.12 , there does seem to be a significant social movement among middle and upper class which is supportive of the alternative healing arts.

<sup>3</sup>Dev Singh's ashramite patients (IIIa,b, and d) consulted him - a person with the kind of intimate personal knowledge of these patients that Freidson expects a folk healer who is well integrated into a person's lay referral structure to have. He probably would consider these patients parochial, regardless of their previous social background.

<sup>4</sup>In subsequent hospitalizations, his patients would often request that he visit them.

<sup>5</sup>What looked like chance to an observer could be considered "intuitive" by the patient (cf. Footnote number 9 , Chapter 11).

## SECTION V

### REFERENCES

#### Chapter 12

Fink R: The measurement of medical care utilization behavior. Conceptual Issues in the Analysis of Medical Care Utilization Behavior. Edited by MR Greenlick. Rockville, Maryland, Department of Health, Education, and Welfare, Public Health Service, 5-32, 1969

Janis IL, Mann L: A conflict theory approach to attitude change and decision-making, Psychological Foundations of Attitudes. Edited by A Greenwald, TC Brock, TM Ostrom. New York, Academic Press, 327-360, 1968

Pratt L: Family Structure and Effective Health Behavior: The Energized Family. Boston: Houghton Miffling Company, 1976

Skinner, BF: Why don't we use the behavioral sciences. Human Nature 1: 86-92, March 1968

#### Chapter 13

Anderson J and Bartkus D: Choice of medical care: a behavioral model of health and illness behavior. J Hlth Soc Behav 14: 348-362, 1973

Becker MH: The health behavior model and sick role behavior, The Health Belief Model and Personal Health Behavior. Hlth Educ Monog 2: 409-419, 1974

Dubos R: Man Adapting. New Haven, Yale University Press, 1965

Fabrega H: Disease and Social Behavior. Cambridge, Massachusetts, The MIT Press, 1974

Feldman JJ: The Dissemination of Health Information. Chicago, Aldine Publishing Company, 1966

Festinger L, Riecken, HW and Schacter S: When Prophecy Fails. Minneapolis, Univeristy of Minnesota Press, 1966

Fink R: The measurement of medical care utilization, Conceptual Issues in the Analysis of Medical Care Utilization Behavior. Editor by MR Greenlick, Rockville, Maryland, Department of Health, Education and Welfare, Public Health Service, Health Services and Mental Health Administration 5-32, 1969

Francis V, Korsch BM and Morris MJ: Gaps in doctor-patient communication. NEJM 280: 535-540, 1969

Freidson E: Client control and medical practice. Amer J Sociol 65: 374-382, 1960

\_\_\_\_\_: Patients' Views of Medical Practice - A Study of Subscribers to a Prepaid Medical Plan in the Bronx, New York, Russell Sage Foundation, 1961

Janis IL, Mann L: A conflict theory approach to attitude change and decision-making, Psychological Foundations of Attitudes. Edited by A Greenwald, TC Brock, TM Ostrom, New York, Academic Press, 327-360, 1968

Kasl SV: The health belief model and behavior related to chronic illness, The Health Belief Model and Personal Health Behavior Hlth Educ Monog 2: 433-454, 1974

Kirscht JP: The health belief model and illness behavior, The Health Belief Model and Personal Health Behavior. Hlth Educ Monog 2: 387-408, 1974

Koos EL: The Health of Regionville. New York, Hafner Publishing Company, 1954

Korsch BM, Gozzi EK and Francis V: Gaps in doctor-patient communication. Peds 42: 855-871, 1968

Levin LS, Katz AH, Holst E: Self-care - Lay Initiatives in Health. New York, Prodist, 1976

McGorkle T: Chiropractice: a deviant theory of disease and treatment in contemporary Western culture. Human Organization 20: 20-23, 1961

McKinlay JB: Some approaches and problems in the study of the use of services - an overview. J Hlth Soc Behav 13: 115-152, 1972

Modell W: Relief of Symptoms. St. Louis, C.V. Mosby Company, 1961

Parsons T: The Social System. New York, Free Press, 1951

Rosenstock IM: Why people use health services. MMFQ, Part 2, 44: 92-127, 1966

: The health belief model and preventive health behavior, The Health Belief Model and Personal Health Behavior. Hlth Educ Monog 2: 354-386, 1974

Schwartz LR: The hierarchy of resort in curative practices: The Admiralty Islands, Melanesia. J Hlth Soc Behav 10: 201-209, 1969

Scott CS: Competing health care systems in an inner city area. Human Organization 34: 105-110, 1975

Suchman EA: Social patterns of illness and medical care. J Hlth Hum Behav 6: 2-16, 1965

Szasz TS and Hollender MH: A contribution to the philosophy of medicine - the basic models of the doctor-patient relationship. Arch Int Med 97: 585-592, 1956

Young MAC: Review of Research and Studies Related to Health Education Practice (1961-1966): What People Know, Believe, and Do About Health. Hlth Educ Monog 23, 1967

Zola I: Pathways to the doctor - from person to patient. Soc Sci Med 7: 677-689, 1973

APPENDIX A

SIGN

I am a fourth year medical student who wants to learn about the many ways of healing that are practiced and used by people, but are not taught in medical school. I am now working on a project to find out just what kinds of healing exist in the Greater New Haven community. If you use non-medical means to help people when they are sick, or know of any such person who does, and would like to talk about it, call Robert McLellan at 562-0081, or write me at the student mailroom:

Yale Medical School  
333 Cedar Street  
New Haven, Connecticut 06515

ADVERTISEMENT

Medical student studying alternate forms of healing wants to talk to healers. Call Robert McLellan at 562-0081 or write box \_\_\_\_\_.

APPENDIX B

Short Interview of Healers

Name:

Address:

Phone Number:

Place of Practice:

Type of Healing:  
philosophy  
description of techniques

Number of Patients Seen Per Week or Month:

Types of Patients:  
demographic characteristics  
types of problems presented

Charge for Services:

Number of Years of Work as Healer:

Type and Extent of  
training:  
other occupations:

Know of Other Healers:

APPENDIX C

CONSENT FOR PARTICIPATION IN A SURVEY OF HEALERS AND THEIR  
PATIENTS: HEALER FORM  
YALE UNIVERSITY SCHOOL OF MEDICINE

Invitation to Participate and Description of Project:

You are invited to participate in a student thesis project for the Yale University School of Medicine. The purpose of this project is to describe the variety of healing arts practiced in the New Haven area, the practitioners and their patients. The information will be used to further our understanding of what healing is and why people use health practitioners other than medical doctors. The project results may also help physicians learn how to better respond to their patients' needs.

You have been selected for inclusion in this survey on the basis of your professional position.

Your participation would include responding to interview questions, permitting my observation of your practice, and filling out a short survey form descriptive of your patients. The interview will take approximately 3 hours and can be arranged at your convenience to take place here, at your home, or at my office at the Yale School of Public Health at 60 College Street. The questions will primarily concern your health beliefs and healing practices. You will also be asked questions concerning your personal background. During the observation of your practice, I request simply to be present in the room. The patient survey form will take about five minutes to fill out for each of a number of patients seen by you during a 30 day period. The precise number of forms to be filled out will depend on how many patients you and other healers normally see in a month.

There may be cases in which I feel it important to offer my medical opinion to the patient. In such a case, I would do so with your knowledge.

All information gathered will be pooled with that of other

participants in the survey in order to get more general ideas about the use of alternative ways of healing. A thesis and perhaps a series of articles will be written on the basis of these general ideas. At times, quotations of your responses may be used anonymously as examples. The story of your practice may be used to exemplify a particular way of healing. Every effort will be made to protect confidentiality by changing potentially identifying features. Further, you may elect to review the relevant section of the report by indicating this desire below and providing your telephone number. In this case, the material will not be published until you are satisfied that your identity has been suitably disguised.

All information obtained for the purposes of the study will be strictly confidential. Your name and address will be kept only in my personal files. Only myself and a handful of colleagues working together on this project will see the interview and observation notes.

You may choose not to participate in this study. If you do choose to participate, you are free not to answer any question and may end the interview or observation at any time. You may exclude my observation or choose not to fill out survey forms at any time. Whether or not you participate in or withdraw from this project will in no way affect your relationship with any health practitioner or health care institution.

Before you sign this form, please ask any question on any aspect of this study that is unclear to you. You may take as much time as necessary to think this over.

Authorization: I have read the above and decide that.....

(name of subject)

will participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

.....  
Signature

.....  
Relationship (self, parent, guardian, etc.)

.....  
Date

.....562-0081.....  
Signature of Principal investigator Telephone

Check here if you wish to review relevant material related to our interview or my observations before their publication.

Telephone \_\_\_\_\_

APPENDIX D

## INSTRUMENT TO AID STUDY OF HEALERS AND THEIR PRACTICE

1. Practice profile.  
What type of practice is it? Is it one of a kind?
2. How busy are you? In the last month (week), how many people have you treated? How many do you see in a day? How long do you spend with them?
3. Are you busier at any particular time of the year (month, week)? How much do you charge?
4. What kinds of problems do you see people for?
5. Do you take care of most any kind of problem or only certain kinds? Which kinds?
6. Do you take care of both acute urgent problems as well as chronic problems? Do you treat people with the flare-ups of their chronic problems as well as helping with their long term management?
7. Do you see people with emotional problems? Spiritual problems?
8. Do you see people who feel alright, but who just want to make sure nothing is wrong with them?
9. Do you see people to help them to prevent illness or do you mostly concentrate on helping people who are sick get better?
10. Do you ever decide not to treat some people who are ill? Why? What are your criteria? What do you tell them? Disposition?
11. Do you ever decide that "nothing is really wrong with a patient despite his or her complaints? What do you tell the person in this case?
12. Do you consider yourself the main source of care for most of your patients (any of your patients)? If not, do you think you could be?
13. Do you think you are usually the first person that your patients seek help from or are you their last resort?
14. What other kinds of healers do your patients see before they see you? Do healers (MDs) refer patients to you?
15. Do you refer patients to other healers (especially to doctors)? What are your criteria for referral?

16. Why might a doctor (or other healer) refer a patient to you?
17. Do you have any interaction with any other orthodox or unorthodox healers and system? Do you ever work together in helping particular individuals? Examples.
18. Do you belong to any formal association or informal groups of other health workers? Must you ever report to them or are they aware of your day to day treatment of individuals?
19. Do you have any assistants or colleagues with whom you practice? What do they do?
20. I'm interested in just who most of your patients are. In general, how old are they? The youngest? The oldest?
21. Do you treat as many males as females?
22. What race are most of them?
23. Where do most of them live?
24. What do most of them do for a living?
25. How much formal schooling would you say most of them have?
26. In what socio-economic class are most of them?
27. Are most of them married, widowed, single or what?

## II. Healer Profile

### A. Personal

1. Demographic characteristics: age, sex, color/ethnic derivation, town of residence, marital status, children, years of education, parents' education, number of siblings.
2. Occupations other than healing? Coordinate? Prior?
3. Personality (investigator's subjective impressions)
4. Religious/spiritual affiliations and practices
  - a. Are you a member of an organized religion? Which?
  - b. How often do you participate in organized religious activities, eg. church, group meditations, etc.
  - c. Do you have your own private beliefs about a higher power?

- d. Do you pray or in some other way attempt to grow in your relationship to this power? Does this power participate in your healing of patients? How? Do symbols of this power themselves have power?
- e. Have you ever had a mystical experience - a sudden new perception of the world?
- f. What do you think will happen to you after your death?
- g. What do you think about sin? Do you believe there is good and evil in our world?
- h. How do you feel the higher power affects your daily life?
- i. Can we affect the course of events or will they proceed no matter what we do?
- j. How do(did) these beliefs affect your decision to become a healer, your thoughts about health and disease, your ability to help people get or stay well? What would have been the consequences if you rejected a "call"?

5. Social group affiliation index

Now I'd like to ask some questions that will help me understand something about your background and the people you relate to.

- a. How long have you lived in your current neighborhood? What kinds of people live there?
- b. Ethnic exclusivity

Do the parents of most of your friends come from the same country as your parents come from? Do you observe special holidays of your people? What is your ethnic background? Are associations with people of this background important to you?

- c. Friendship solidarity

Are almost all your friends people you grew up with? Are most of your close friends also friends with each other? Do most of your friends have the same religion as you do? Do most of your friends come from families who know each other well?

- d. Family tradition and authority orientation

In your family, do you think the old-time customs and traditions are important?

6. How did you become involved in helping sick people?
  - a. Social and family history
    - (1) Have there been other people close to you who helped the sick: Did relatives or close friends encourage you to practice your healing art?
    - (2) Have there been especially memorable illnesses in those close to you that influenced your decision?
  - b. Have there been special experiences like calls from above, miracles, or other such happenings which affected your decision?
  - c. Past psychiatric and medical history
    - (1) Have you or family ever been hospitalized or has there been any serious illness in your own life?
    - (2) How was this illness treated? What did you think of your treatment of your caregivers?
  - d. Did you think that helping sick people (or well people stay well) would provide you with the means to live comfortably?
- B. Professional Background
  1. Did you ever want to be a doctor?
  2. What kind of training have you had in learning your healing art? How were you selected for this training? Can anyone take this training? How much did it cost? Is there continuing training?
  3. What are the requirements and characteristics of this training?
  4. Do you continue to learn new things? How?
  5. Are there any formal means of assessing when you are accomplished enough that you may begin your practice? eg. exams, licensure, peer review? Are these controls voluntary or are they legislated by the state? Do you think there should be regulations?
  6. Are there other, more informal ways of describing your competence, eg. patient reports? Do you think there are quacks who make claims to heal? How do you know who a quack is?

7. How long have you been in practice? In New Haven? Where else? Why did you move?
8. Do you participate in the training of other healers? How?

C. Health beliefs and attitudes

1. What do you think doctors and modern medicine have done for our health?
2. Medical skepticism index

Now I'd like to get your views on health care, doctors, and hospitals.

- a. If people feel good, should they get a general physical exam from their medical doctor every year?
- b. Do people get over most any disease without getting medical aid?
- c. Do you have doubts about some things medical doctors say they can do for you?
- d. Do you believe in trying out different medical doctors to find which one will give you the best care?
- e. Are some home remedies still better than prescribed drugs for curing illness?
- f. Does a person understand his or her own health better than most medical doctors do?
- g. Can modern medicine cure most any disease?
- h. Is the medical profession about the highest calling a person can have in this country?
- i. If a doctor told you that you needed a major operation, would you have it done immediately?
- j. Is a medical doctor the first person you turn to if you have a question about your health that you or your friends can't answer?

3. What do you like best about medical doctors? Like least?

4. Disease - Now I'd like to get your views on disease.
  - a. What is disease? How do people know when they are sick?
  - b. Can disease be separated from the person, i.e. is it an entity unto itself?
  - c. Are 2 diseases ever alike; or is each one different? Does one person with a sore throat have the same problem as another person with a sore throat?
  - d. Is there one treatment for everyone with the same complaint or is there a different treatment for each person?
  - e. Why do some people get sick while others don't?
  - f. What causes disease? Are there different causes for different problems? Can 2 different types of causes produce the same disease? Can 1 cause produce more than 1 kind of disease?
  - g. Do males/females, young/old tend to get different kinds of disease or do they all pretty much have the same problems? Different causes of disease for different ages or sexes?
  - h. Is aging inevitable? What causes aging?
  - i. Can degenerative diseases like arthritis or heart disease be cured, i.e. as if the person had never had the disease?
5. Health - Now I'd like to get your views on health.
  - a. What is health? How do you know if you're healthy?
  - b. Do you have to work at it constantly to have good health, or is good health natural? What do you do?
  - c. Is how we take care of ourselves more important to our health than the body we are born with?
  - d. What other kinds of things do you do to maintain or promote your health? Spiritual? Psychosocial? Physical?
6. Healing - Now I'd like to get your views on healing.
  - a. What is healing? How does it happen? What do you do to help it happen?
  - b. What types of intervention are necessary? Psychosocial? Structural/functional eg. mechanical or pharmacologic? Supernatural?

- c. Or is no intervention necessary, i.e. does the body heal itself?
- d. How would you compare your effectiveness in healing to an MD's? Are you more effective for some problems while a physician is better for others? What are your criteria for judging your effectiveness?
- e. Do your patients always get better? If not, why not? What do you do if you perceive that your treatments are not working?
- f. Do your treatments have any side effects?

#### D. Medical Knowledge

I'd like to ask you some questions about how you view particular illnesses. First tell me what you know about the disease. Then tell me in what other ways a medical doctor might recognize the disease.

- 1. What are the signs and symptoms of cancer that you look for? How do they differ from those a MD looks for?
- 2. Sugar diabetes
- 3. Heart attack

#### E. Expectations and Satisfactions of the Healer/Patient Relationship

- 1. Why do patients come to you in particular?
- 2. Why do you think a patient would come to you rather than a doctor or other health worker?
- 3. From your patient's point of view, what do you think is the most important aspect to the patient of his or her visit with you?
- 4. What do you think is the most important part of your visit with a patient?
- 5. Do you find that the patient's chief complaint is usually the most important problem you treat?

6. Do you find that there are reasons for patients' visits other than those stated by the patient?
7. What are the most frequent problems in your relationship with patients?
8. What are the main characteristics of an ideal patient (doctor) as far as you are concerned?
9. Would you say that many of your patients are like that?
10. Your patients will be asked what they like most and least about you as their healer? What do you think they will like most? Least?
11. Should you be friends with a patient?
12. Do you expect to be the only healer taking care of an individual?
13. What do you like best about working with patients (least)?
14. Is there ever a conflict between what you and the patient think should be done? If so - what kinds of conflict? What happens? Who makes the decisions?
15. Do you think patients take your advice? How do you know?
16. Do you ever think that patients come to you too late (too often)?
17. Why do you think they may put off seeing you?

### III. Healing Practice

- A. Modes of diagnosis and treatment used: description, theory and perceived efficacy.
- B. Description of equipment, devices, assistants.
- C. Case studies of treatment

In particular observe for locus of decision-making, patient education and participation in process. Score number of questions and statements patient makes.

#### IV. Role of Healer in Community

- A. Do you have any social responsibilities outside of caring for your patients which are, however, associated with your position as a healer?
- B. What do you feel are the biggest problems faced by (type of healer) in New Haven in their relation with the public? With organized Medicine? Do you have problems with police, health department, etc.
- C. What should be done to deal with these problems?
- D. Social status.

APPENDIX E

OF THE INDIVIDUAL WILL BE HELD IN STRICT CONFIDENCE.

APPENDIX F

PATIENT FORM A - OBSERVATION ONLY  
CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT  
YALE UNIVERSITY SCHOOL OF MEDICINE

Invitation to Participate and Description of Project:

You are invited to participate in a student thesis project for the Yale University school of medicine. The purpose of this project is to describe the variety of healing arts practiced in the New Haven area, the practitioners and their patients. The information will be used to further our understanding of what healing is and why people use health practitioners other than medical doctors. The project results may also help physicians learn how to better respond to their patients' needs.

Your participation would consist of permitting my observation of your treatment. During the observation of your treatment, I will simply be present in the room.

The information gathered for this project will be pooled with that of other participants in the survey in order to get more general ideas about the use of alternative ways of healing. A thesis and perhaps a series of articles will be written on the basis of these general ideas. At times, my observation of your treatment may be used anonymously as examples. If these observations are included in any report, every effort will be made to protect confidentiality by changing potentially identifying features. Further, you may elect to review the relevant section of the report by indicating this desire below and providing your telephone number. In this case, the material will not be published until you are satisfied that your identity has been suitably disguised.

Thus all information obtained for the purpose of the study will be strictly confidential. A record of your name and telephone number will only be kept in my personal files if you desire to

review material to be published related to my observation of your treatment. Otherwise there will be no record or mention of your name anywhere. Only a code will be used. And, only myself and a handful of colleagues working together on this project will see the field notes.

You may choose not to participate in this study. If you do choose to participate, you are free to end the observation at any time. Whether or not you participate in or withdraw from this project will in no way affect your treatment, or your relationship with any health practitioner or health care institution.

Before you sign this form, please ask any question on any aspect of this study that is unclear to you. You may take as much time as necessary to think this over.

       Check here if you wish to review material related to this observation before its publication. Telephone \_\_\_\_\_

Authorization: I have read the above and decide that.....  
(name of subject)  
will participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

.....  
Signature

.....  
Relationship (self, parent, guardian, etc.)

.....  
Date

.....562-0081.....  
Signature of Principal investigator Telephone

CONSENT FOR PARTICIPATION IN A SURVEY OF HEALERS AND THEIR  
PATIENTS: PATIENT FORM B

YALE UNIVERSITY SCHOOL OF MEDICINE

Invitation to Participate and Description of Project:

You are invited to participate in a student thesis project for the Yale University School of Medicine. The purpose of this project is to describe the variety of healing arts practiced in the New Haven area, the practitioners and their patients. The information will be used to further our understanding of what healing is and why people use health practitioners other than medical doctors. The project results may also help physicians learn how to better respond to their patients' needs.

Your participation would include responding to interview questions and permitting my observation of your treatment. The interview will take approximately 2 hours and can be arranged at your convenience to take place here, at your home, or at my office at the Yale School of Public Health at 60 College Street. The questions will concern primarily your present illness and what you have done for it. You will also be asked questions about your health and personal background. During the observation of your treatment, I will simply be present in the room.

The information gathered for this project will be pooled with that of other participants in the survey in order to get more general ideas about the use of alternative ways of healing. A thesis and perhaps a series of articles will be written on the basis of these general ideas. At times, quotation of your responses may be used anonymously as examples. Every effort will be made to protect confidentiality by changing potentially identifying features. Further, you may elect to review the relevant section of the report by indicating this desire below and providing your telephone number. In this case, the material will not be published

until you are satisfied that your identity has been suitably disguised.

Thus all information obtained for the purpose of the study will be strictly confidential. A record of your name and telephone will only be kept in my personal files if you desire to review material related to our interview or my observation of your treatment. Otherwise there will be no record or mention of your name anywhere. Only a code will be used. And, only myself and a handful of colleagues working together on this project will see the field notes.

You may choose not to participate in this study. If you do choose to participate, you are free to end the observation at any time. Whether or not you participate in or withdraw from this project will in no way affect your treatment, or your relationship with any health practitioner or health care institution.

Before you sign this form, please ask any question on any aspect of this study that is unclear to you. You may take as much time as necessary to think this over.

Authorization: I have read the above and decide that.....  
..... (name of subject)  
will participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

.....  
Signature

.....  
Relationship (self, parent, guardian, etc.)

.....  
Date

562-0081

.....  
Signature of Principal investigator Telephone

Check here if you wish to review material related to the observation or interview before its publication. Telephone \_\_\_\_\_

APPENDIX G

## INSTRUMENT TO AID STUDY OF PATIENTS

### I. Presenting Symptoms

#### A. Chief complaint

#### B. Standard medical history of present illness with following emphasis:

1. What are symptoms? When did you first notice them? How did they come to your attention? Do they interfere with your everyday activities? How?
2. Intensity, duration, quality, ambiguity, amelioration/aggravation, history.
3. Experience with symptoms - commonality and familiarity of symptoms: Have you ever known anyone else who had these problems? What was wrong with them? What did they do? What happened? Have you ever had these symptoms before? What did you do? Did anyone like a doctor or healer tell you what was wrong? What happened? Have you learned anything about this problem by reading or talking to people? What is the impact of this illness on your life? Past, present, future?
4. Do you have any idea of what is wrong now? Why?
5. Perceived seriousness - Do you think this is a serious or not so serious problem? What do you expect will happen?
6. Did you ever wonder why it was you who got sick? Why now?

#### C. Decision Pathway

1. I'm particularly interested in what you have done since you first decided you were not well. What did you first think was wrong? Did you ask anybody's opinion? What did they say? What were your thoughts at that point? What did you do? Why? Did it help? Have you changed your mind about what is wrong? How and Why? Did you change your treatment? Did you seek help? What kind of help? What made you decide to seek further help? What worried you most? Did you ever think of going to a doctor or clinic? Why? Did you? What happened? Did it help. What worries you most now? How do you think you could best be comforted?

2. Why did you come to this healer? Why now? How did you hear about this healer? Ever been here before? Why? What happened? What kind of treatments did you receive? What did you think of his/her office? What do(did) you think this healer can(could) do for you? Did you follow his/her advice? What were you supposed to do? Do you have to see him/her again? Was there a charge? Is s/he cheaper than regular medical care? Will you(did you) seek someone else's advice?
3. Do you think the treatments helped? What makes you think that? How do you think they worked? Are you satisfied with what happened? What do you think about his/her competence? What do you believe a quack is? Do you recommend this healer to other patients?
4. Did this healer or anyone else explain why you got sick now? Who explained? What was the explanation? Was it helpful? Did it make you feel better or worse?
5. Did anyone tell you what to expect in the future in terms of the course of your illness?

D. Dependency/Independency

1. Would you rather that the healer make most of the decisions regarding your treatment now or would you like to participate in this decision making? Does this healer let your participate? What about other health workers you've been to?
2. Are you used to taking care of yourself when ill, or do you welcome other people's help? What about now?
3. Do you find it hard to give up people doing things for you when you start getting well?

II. Expectations of and Satisfactions with Healer/Patient Relationship

- A. Do you think that this healer understands what is bothering you? What about the last time you saw a medical doctor - did he or she seem to understand? Is there anything that you feel you can't talk to him/her about?
- B. Is it important to you that a healer be able to explain why it was you who got sick now or is it enough if he or she can simply help you get better? What kind of explanation do you look for?

- C. Is it ever difficult for you to tell a health worker, eg. MD, nurse or healer, what is really bothering you? Does this healer help you talk about what is bothering you? What about other healers? Your medical doctor?
- D. Would you rather that the person helping you just take care of you and tell you what to do or is it important that he or she explain problem to you so you can share in the decision as to what should be done?
- E. What are the main characteristics of an ideal healer (patient) as far as you're concerned?
- F. Why do you got to this healer? What do you think he can do for you? Do you see him when you are feeling OK? Why?
- G. Why would you go to a medical doctor? Do you go to a medical doctor for different reasons than you go to this healer? How do you use a doctor in conjunction with a healer?
- H. What do you think is the most important part of a visit with a healer? What is the most important thing he/she can do for you? How does this affect you(your illness)?
- I. Has there ever been a time when you didn't agree with a doctor's advice? Example? What did you do?
- J. Has there ever been a time when you didn't agree with a healer's advice? Example? What did you do?
- K. What do you like most about receiving health care from this healer? Like least?
- L. Are you friends with him/her?

### III. Past Medical History and IV. General Health Status and Behavior

- A. would you say that you think about your health a great deal, some of the time, hardly at all or not at all?
- B. In general, how is your health? Would you say excellent, good, fair, or poor?
- C. Do you think your health is better or worse than most people your age?

- D. Are you physically able to do all the things you would like to or do you have some limitations? If so what kind and what do you do about them?
- E. In the past year, how many days did you stay at home in bed all or part of the day because you were not feeling well?
- F. In the last 12 months, how many nights did you spend in a hospital? Have you ever had to stay overnight in a hospital?
- G. How many times have you seen a doctor during this time? A healer?
- H. Have you ever had any serious illnesses in your life which have forced you to stop your normal activities for two or more weeks? What was wrong? What did you do?
- I. Do you have any other illnesses now? What are you doing about them?
- J. Do you take any prescription medicines at the present time? Why? What are they? Do you take any medicines, herbs or special foods not prescribed by a doctor? Why? What do you take? Who told you to take them?
- K. Any other treatments prescribed by a doctor? Not prescribed?
- L. Have you ever or are you now receiving professional counselling from a social worker, psychologist or other mental health worker?
- M. Health Behavior
  - 1. Where do you get most of your health information? Do you ever head books or magazines devoted solely to health? Which ones?
  - 2. Do you follow a particular diet? What kind and why?
  - 3. Do you get regular exercise? How much and what kind?
  - 4. Do you smoke? Drink?
  - 5. When was the last time you went to a dentist?
  - 6. Do you take time most every day to relax? How?
  - 7. Have you ever been concerned about your weight? What did(do) you do about it?

## N. Illness Behavior

1. What worries you most about your health?
2. What do you do about this problem? Who have you seen? What did they do or recommend? Have you followed this advice?
3. How do you know when you are sick?
4. What do you usually do when you're not feeling well?
5. How do you decide that you need help?
6. Many people, devices, or places can be helpful to you when you are ill or need medical advice. What have you done?
7. For what problems are they helpful?
8. Do you use more than one source of help at a time or over the course of an illness? Are the various healers aware of this?
9. Do you have a particular person that you usually go to about your health? Who?
10. Do you see him/her on a regular basis or only when problems arise?
11. When was the last time you saw or talked to this person about your health?
12. (If person is not a doctor, ask 9-11 again, substituting doctor).
13. Where do you usually go when you want to see a doctor - to a clinic, a hospital, the doctor's office, or some other place?

## O. Barriers to and Satisfaction with Medical Care

1. As I'm sure you realize, sometimes people don't always get the health care that they think they need. There are a lot of different reasons for this. How much of a problem has this been for you? What has the problem been?

2. Has there ever been anything that a doctor has suggested you do for your health that you have not been able to do? What and Why?
3. As you think over the health services and medical care you and those close to you have received over the past few years from doctors and hospitals, how satisfied have you been with the care? What about the last time you got help?

#### V. Health Beliefs and Attitudes

- A. Do you think that the health of Americans has improved in the past fifty years? Why?
- B. What do you think medical doctors and modern medicine have done for our health?
- C. Medical Skepticism

Now I'd like to get your views on health care, medical doctors, and hospitals.

1. If people feel good, should they get a general physical exam from their medical doctor every year?
2. Do people get over most any disease without getting medical aid?
3. Do you have doubts about some things medical doctors say they can do for you?
4. Do you believe in trying out different medical doctors to find which one will give you the best care?
5. Are some home remedies still better than prescribed drugs for curing illness?
6. Does a person understand his or her own health better than most medical doctors do?
7. Can modern medicine cure most any disease?
8. Is the medical profession about the highest calling a person can have in this country?
9. If a doctor told you that you needed a major operation, would you have it done immediately?

10. Is a medical doctor the first person you turn to if you have a question about your health that you or your friends can't answer?

D. What do you like best about medical doctors? Like least?

E. Disease - Now I'd like to get your views on disease.

1. What is disease? How do people know when they are sick? What do you think about germs?

2. Can disease be separated from the person, i.e. is it an entity unto itself?

3. Are 2 diseases ever alike, or is each one different? Does one person with a sore throat have the same problem as another person with a sore throat?

4. Is there one treatment for everyone with the same complaint or is there a different treatment for each person?

5. Why do some people get sick while others don't?

6. In general, what causes disease? Are there different causes for different problems? Can 2 different types of causes produce the same disease? Can 1 cause produce more than 1 kind of disease? Why does illness exist?

7. Do males/females, young/old tend to get different kinds of disease or do they all pretty much have the same problems? Different causes of disease for different ages or sex?

8. Is aging inevitable? What causes aging?

9. Can degenerative diseases like arthritis or heart disease be cured, i.e. as if the person had never had the disease?

F. Health - Now I'd like to get your views on health.

1. What is health? How do you know if you're healthy?

2. Do you have to work at it constantly to have good health, or is good health natural? What do you do?

3. Is how we take care of ourselves more important to our health than the body we are born with?

4. What other kinds of things do you do to maintain or promote your health? Spiritual? Psychosocial? Physical?

G. Healing - Now I'd like your views on healing.

1. What is healing? How does it happen? What do you do to help it happen?
2. What types of intervention are necessary? Psychosocial? Structural/functional (eg: mechanical or pharmacologic)? Supernatural?
3. Or is no intervention necessary, i.e. does the body heal itself?
4. How would you compare the effectiveness of your healer's treatments to those of medical doctors? Is the healer more effective for some problems and a medical doctor for others? How do you judge effectiveness? i.e. how do you know when you're healed?
5. Do you consider yourself a healer? Have you ever helped others with their disease?

H. Medical Knowledge

I'd like to ask you some questions about how you view particular illnesses. First tell me what you know about the disease. Then tell me in what other ways a medical doctor might recognize the disease.

1. What are the signs and symptoms of cancer that you look for? How else might an MD suspect that you had cancer?
2. Diabetes
3. Heart attack

VI. Religious/Spiritual Affiliations and Practices

1. Are you a member of an organized religion? Which?
2. How often do you participate in organized religious activities, church, group chanting or meditations, etc.
3. Do you have your own private beliefs about a higher power?

4. Do you pray or in some other way attempt to grow in your relationship to this power? Does this power help you stay healthy or get better when you are ill? How?
5. Have you ever had a mystical experience - a sudden new perception of the world?
6. How do you believe the world was created?
7. What do you think will happen to you after your death?
8. What do you think about sin? Do you believe there is both good and evil in our world?
9. How do you feel the higher power affects your daily life?
10. Can we affect the course of events or will they proceed no matter what we do?
11. How do these beliefs affect your decisions about seeking health care, your thoughts about health and disease, your ability to stay healthy and get well? Do you think God sends sickness as a punishment? How can a higher power permit sickness?

#### VII. Social Group Affiliation

- A. Now I'd like to ask some questions that will help me understand something about your background and the people you relate to.
  1. How long have you lived in your current neighborhood? What kind of people live there?
  2. Ethnic exclusivity - What is your ethnic background? Do you observe special holidays of your people? Are associates with people of this background important to you? Do the parents of most of your friends come from the same country as your parents? Do you prefer to deal in stores where clerks are the same kind of people as you are? What do your friends, neighbor or family think of your use of alternative practitioners? Do they use alternative practitioners?
  3. Friendship solidarity - Are almost all of your friends people you grew up with? Are most of your close friends also friends with each other? Do most of your friends come from families who know each other well?

4. Family tradition and authority orientation - Who is the head of your household? Is there a history of family tradition that you respect?

VIII. Personality - subjective mental status

IX. Demographic

Age, sex, color/ethnic derivation, town of residence, marital status, children, years of education, occupation, health insurance, how much pay for health care per year.

APPENDIX H

#### CRITERIA OF MEDICAL KNOWLEDGEABILITY

1. Knowledgeability of cancer was judged by the number of American Cancer Society 7 warning signals that a patient was able to state unaided. The signals are: (1) change in bowel or bladder habits, (2) a sore that does not heal, (3) unusual bleeding or discharge, (4) thickening or lump in breast or elsewhere, (5) indigestion or difficulty in swallowing, (6) obvious wart mole, (7) nagging cough or hoarseness.

A study sponsored by the American Cancer Society (1967) showed that 31% of the American population could not recall one of these seven signals. Sixty-nine (69%) remembered at least one sign.

Any sample patient who could not remember one sign was judged Unknowledgeable. Remembering one to two signs merited a Knowledgeable rating. A patient stating greater than 2 signs was judged as Very Knowledgeable.

2. Knowledgeability of diabetes mellitus (DM) and myocardial infarction (MI) was judged on the basis of the patient's ability to recall specific signs and symptoms of the diseases. Patients were scored Unknowledgeable if they had little or no general understanding and/or could only suggest that DM had something to do with "sugar" and that an MI was associated with chest pain. A patient was scored Knowledgeable if s/he was able to mention at least 3 signs and/or symptoms for both DM and MI. A patient was judged as Very Knowledgeable if s/he knew more than 3 signs and/or symptoms for each disease.

Responses counted as correct included: polydispia, polyphagia, polyuria, poor healing, visual changes, associated atherosclerotic diseases, hypertension, renal complications, glycosuria, and hypoglycemia. Responses considered correct for MI included: chest pain, pain in arms or jaw, nausea, palpitations, diaphoresis, dizziness, loss of consciousness, ashen complexion. Patients were also credited with 1 symptom if they demonstrated an overall understanding of the disease process.

3. Subjectively, I scored patients as Unknowledgeable, Knowledgeable, or Very Knowledgeable in terms of their understanding of the etiology, prognosis, medical implications and orthodox treatment for their present illness.

#### REFERENCE

A Study of Motivational, Attitudinal and Environmental Deterrents to the Taking of Physical Examinations that Include Cancer Tests. New York, Lieberman Research Inc., (Sponsored by the American Cancer Society), 1966.

APPENDIX I

#### ASSESSMENT OF MEDICAL ORIENTATION

Assessment of patients' medical orientation was based on their responses to the 10 questions in Section V of the patient interview schedule in combination with any strong statements the patients might have offered at some point during the interview. Patients were judged as Pro-medicine, So-so, or Anti-medicine to control for "yes-saying," 5 Pro-medicine questions required an affirmative response, whereas the other 5 required a negative response. Pro-medicine responses were scored as "0" and Anti-medicine responses were scored as "1." A patient scoring less than 4 was judged as Pro-medicine. A patient scoring between 4 and 6 was judged as "So-so." And a patient scoring 7 or greater was judged as Anti-medicine. Regardless of the score made on these questions, patients who made strong statements about their medical orientation were judged according to that statement.









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